DOCUMENT RESUME

ED 402 066 PS 024 837

AUTHOR	Mayall, Berry; And Others
TITLE	Children's Health in Primary Schools.
SPONS AGENCY	Economic and Social Research Council, Lancaster (England).
REPORT NO	ISBN-0-7507-0545-0
PUB DATE	96
NOTE	290p.
AVAILABLE FROM	Falmer Press, Taylor and Francis Inc., 1900 Frost Road, Suite 101, Bristol, PA 19007.
PUB TYPE	Books (010) -- Reports - Research/Technical (143) -- Tests/Evaluation Instruments (160)
EDRS PRICE	MF01/PC12 Plus Postage.
DESCRIPTORS	*Child Health; *Elementary Education; Elementary School Students; Foreign Countries; Health Conditions; *Health Needs; *Health Promotion; School Attitudes; *School Health Services; School Policy; School Responsibility; School Role
IDENTIFIERS	Child Care Costs; Child Care Needs; Child Health Questionnaire; Child Nutrition Programs; *Health Hazard Appraisal; Health Policy; *Health Standards; Health Status; Health Surveys; School Based Services; School Effects; School Influence

ABSTRACT

Positing the relevance of well-being and social support to educational achievement, this book explores the status of children's health and its importance to the education of young children. A mail questionnaire survey of 1031 of approximately 20,000 Primary Education Schools in England and Wales in the fall of 1993 yielded 620 replies; a response rate of 60 percent. Data from this survey and six case studies call attention to conditions that are necessary for children to learn. These factors include good health, a nutritious diet, enough exercise, a safe and comfortable environment, happiness, and good sanitation. The book is divided into three parts: (1) "The Survey", describing the instrument, the buildings inspected, accidents and illness, health education and school health services, and a commentary; (2) "The Case Studies", detailing reports of a month spent at each of six schools; (3) "The View from the Children," showing their perspective on their schools; and (4) "Discussion," summarizing the status of children's health at school, issues of interrelationships between agencies, and the division of labor for the care of children. Appendices include the survey questionnaire and methodology, tables, facts about case-study participants, and schedules. Contains 116 references. (AMC)

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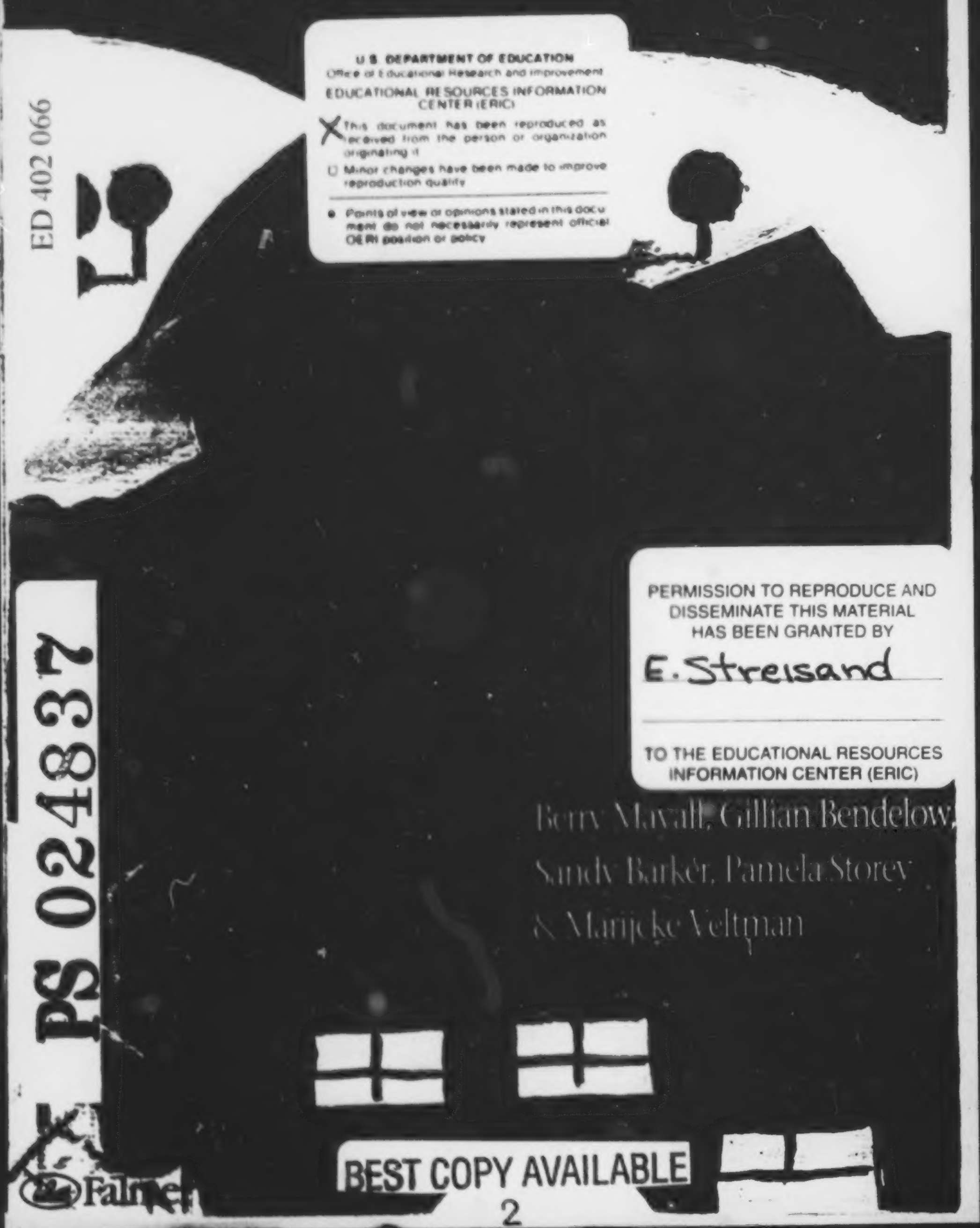

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Children's Health in Primary Schools

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Berry Mayall, Gillian Bendelow, Sandy Barker,
Pamela Storey and Marijcke Veltman

with a foreword by Ann Oakley

The Falmer Press
(A member of the Taylor & Francis Group)
London • Washington, D.C.

UK Falmer Press, 1 Gunpowder Square, London, EC4A 3DE
USA Falmer Press, Taylor & Francis Inc., 1900 Frost Road, Suite 101,
Bristol, PA 19007

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First published in 1996

A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data are available on request

ISBN 0 7507 0544 2 cased
ISBN 0 7507 0545 0 paper

Jacket design by Caroline Archer

Typeset in 10/12 pt Garamond and printed by
Graphicraft Typesetters Ltd., Hong Kong

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Acknowledgments

This study owes a lot to many people whose help made it possible. We are very grateful to the school staff who made the time to fill in our questionnaire. We owe a great debt to the staff, children and parents in our case-study schools, who gave us their time. These many people provided us with the comments, accounts and insights that enliven our own prose. The view from the children includes not only their words, but their drawings, which we have scattered through the book, as commentaries on the adult views we, staff and parents express. The study was funded by the Economic and Social Research Council (ROOO 23 4476) for thirty months from July 1993, and we are grateful for their financial support.

Foreword

Writing about *English Sanitary Institutions* in 1897 (published by John Murray), the public health enthusiast, Sir John Simon, took the view many have since shared that 'Education, in the full sense of the word, is the one far-reaching true reformer' (Simon, 1897, p. 481). By 'education' Simon meant not 'the mere elementary school-business of reading and writing and arithmetic' but the development of children in the direction of self-help and social duty. His own major concern was with the growth of preventive medicine, a subject since given different titles — public health, health education, and, most recently, health promotion. But improving the national health could not simply be viewed as a medical matter: Simon was all too aware of the dangers of sectarianism — of that 'spirit of exclusiveness' which works against the promotion of the common good by dividing up people's well-being into different domains, each of which belongs to a different professional group.

The people's health and their education have moved on since 1897, but the unity of purpose that was part of Simon's vision and that of other health and education reformers has not come to pass. This important and timely book about children's health at school shows very clearly how professional ideologies and practices continue to divide education from health and from welfare in the broadest sense. Children go to school to learn: they do not go to school to stay or become healthy. Insisting on the primacy of learning ignores those conditions which are needed for learning to take place: good health, a nutritious diet, enough exercise, a safe and comfortable physical environment, happiness. We must, of course, (following Simon's precedent) add good sanitation to that list. The condition of school toilets emerges as a major concern for many children, parents and teachers in both the large-scale survey of school practice and the local case-studies reported in this book. On one level it is simply shocking that in the UK today, children should be expected to tolerate the kinds of conditions obtaining in some of the survey schools. A third were housed in pre-1903 buildings; a fifth had toilets considered 'poor' or 'very poor' by staff. In one of the case-study schools all the toilets were housed in a bleak, separate block so that children had to put their coats on in winter to go there, and teachers were unable to provide any supervision.

Poor material conditions combine with cuts in staffing and other resources to create a picture of a service under siege. In one school, the cleaning staff had been reduced from fourteen to four. Class size is increasing, teachers find it hard to teach and children complain about noise and overcrowding. But what emerges very strongly is the tremendous resilience and commitment of school staff to doing the very best they can for the children in these trying circumstances. The book contains many moving vignettes. For example, in one school where children entitled to free school meals are supplied by the LEA only with packed lunches, the secretary patiently repacks these in the children's own lunchboxes every day so that they will be spared the stigma of being singled out by other children.

More than anything else, however, the data in this book reveal the hollowness of the rhetoric of that politically correct term 'the health-promoting school'. There is not very much about most of these schools that is perceived by children as promoting their health. By the time children go to school they have picked up the major health education messages about a good diet, but the diet provided at school is often far from good. Playtime and the playground emerge as uncomfortable and dangerous for many children, particularly for younger children and for girls, who report negative experiences of playgrounds dominated by boys practising their infant masculinity. Contrary to adult beliefs, playtime is not the best thing about school for 1 in 2 children, and, for 1 in 3, bullying is the worst. Children value having quiet places at school and sympathetic adults to confide in. The problem is that national educational policy is not based on what children value, but on a particular view about what they ought to have, and become.

At the centre of this book is the question of childhood. Who does childhood belong to? What should childhood be like? What do people mean when they speak about 'children's best interests'? What *are* children's best interests? The significance of these issues is one reason why research questions about children's social position cannot be answered without seeking their views, however difficult this may be perceived to be. Children want to be listened to, whatever story they have to tell (and some of those in this book about illness and the need for teachers to take children seriously, are very poignant). As these data show, the extent to which children are consulted about school policies and practices is very limited. For example, only 11 per cent of schools had any mechanism for including children in choosing menus, despite the fact that many in the formal curriculum teach children how to make healthy food choices.

The picture is one of a system divided against itself, of children being exposed to conflicting messages, of children being expected to do well in a 'total institution' which is not child-centred, but centred on adult views of what children need. The adult division of labour here is of course quite fascinating. Fathers hardly enter the picture. This is because it is primarily mothers who manage children's health and also the school–home divide. Moreover, schools are also full of mums, with teachers and other school staff taking caring responsibilities in addition to whatever it is they are paid to do. Informally, many primary school teachers, dinner ladies, playground supervisors, school secretaries and so forth have long grasped the fact that few people can do well unless they feel cared for. It is unfortunate that this extremely key message about the relevance of social support and well-being is seen as belonging to the health sector, and not as relevant to educational achievement.

The data presented in this book constitute a damning indictment of current government policy. It is precisely in this besieged state that key actors are likely to complain about one another — and there is some victim-blaming of parents by teachers and by parents of schools in the research data described in the book. The reality, however, is that parents and teachers and children all have an increasingly difficult task to perform. Questions about children's health at school are no longer confined to episodes of nit infestation (though nits are still very much on the agenda), or the rare visits of the school doctor (though the future of the school health service is an important question). The primary question is whether we as a society are sufficiently interested in children as a social group to give them the rights, resources and responsibilities they deserve.

Ann Oakley
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Introduction

This book explores the status of children's health in primary schools, using data from a large-scale survey and six case-studies. Our exploration focuses on intersections of health and education, two topics which are commonly considered separately. For whilst the home is usually regarded as the site of health care, the school stands as the site of education. Yet education also takes place at home, and health care at school. Children themselves challenge the division of lived life into private and public sectors; they take their bodies and emotions, as well as their minds, into school each day. For them the maintenance of health there is a key concern.

Adults commonly assume that children have purposes in going to school and that these are in harmony with influential adults' purposeful structuring of children's days.

> Children don't go to school for an 'experience'. They go to learn the basic skills they are going to need in later life — being able to read, write and do sums. (John Major, 1994, quoted in Pollard, 1996, p. 316)

But we start from children as people, as a social group who have to spend their days at school. The research enterprise is similar to that in Bellaby's study (1992) of pottery workers: for people spending their day in a specific kind of social organization, how does health maintenance work out?

We approach consideration of school as a health-related institution, not through medical eyes, nor educational eyes, but through taking account of the material and social character of schools. Like the authors of the 1980 Black Report (Townsend and Davidson, 1982), we claim that physical and social resources are essential ingredients determining health status, as much as knowledge and the will to implement it. So in this book we study the physical environment of schools, the social order and the beliefs and activities of the health care actors — children and the adults who order their lives at school.

Schools are complex organizations, whose character, ideologies and practices derive from many sources. In a literal sense, children's experience at school is structured by the physical environment. Many children in England and Wales work in schools built for educational purposes long abandoned; for example, over two-fifths of the schools in our survey were built to house school policies in place before the Education Act 1944 defined the character of primary education for the ensuing generations. Nowadays, under pressure of financial cut-backs, children (see pp. 147–8) are working in classes of thirty or more, crowded into classrooms designed in the 1960s for no more than twenty-four children, in an era when learning through experience was fashionable. Playground experience is also heavily dependent on the physical environment. The classic tarmacked spaces surrounding many older schools offer restrictive, crowded and hostile environments designed at a time before children's active, constructive play was regarded as educational, and became a factor in design.

Experience of living within, and participating in, the construction of the social order of the school is key to children's well-being. And listening to children talk reminds us adults of critical linkages between the physical and social environment. Children's relationships with other children and with adults are worked out in tension with the physical environment. Their well-being is constructed through that interactive process. A small, crowded playground, where football is allowed, is a hostile and dangerous place; and one where a child needs friends to protect her physically and morally from assault. In all our case-study schools, bullying was a problem — even though staff had taken measures to tackle it; and the free-for-all character of playtime, with limited supervision (for it is costly), offered a social and material framework within which bullying could flourish. Relationships with adults also matter. The case-studies indicate that for children one of the worst things about school is being shouted at and told off; but teachers' behaviour results partly from the linked stresses of managing large classes in small spaces, and of meeting National Curriculum targets. Within the framework of uncertain and sometimes hostile child–staff relationships, some children are cautious about approaching adults for help in case of need. Our data on help-seeking for accident and illness indicate that they cannot assume they will get responsive care; yet they need adult legitimation of their condition in order that they may 'go sick'.

Staff in schools consider and enact the enterprises of health maintenance and health promotion under the influence of history, finance, national policies and individual initiative. 'Health promotion', as understood in WHO (World Health Organisation) documents (e.g., WHO, 1993), encompasses the enterprise of working towards a physical and social environment which, coupled with education, will enable and encourage the enactment of health-related knowledge. There is considerable enthusiasm among UK policy-makers for teaching children 'health education'; it is categorized as a cross-curricular topic in the National Curriculum. Yet with stringently restricted budgets, schools are unlikely to be able to improve school as a health-promoting environment for children. One purpose of the research was to study and document what schools do to improve the physical and social setting within which they and the children have to live. Another was to explore what relationships children perceived between health education messages and health-related provisions at school.

Within the broad scope of health promotion, we focused on two key topics — key, in that children themselves identify them as the main factors affecting health: nutrition and exercise. The provision of food at school is structured through traditional assumptions — that there should be a nutritious school dinner — established after bitter battles in the first seventy-odd years of state education (Hurt, 1979, Chapter 5); through the 1980 Education Act, which abolished nutritional standards and the requirement to provide meals; through local education authority (LEA) and school financial health; and through individual schools' policies. Physical activity at school again depends on intersections of similar factors. Playtime is a hallowed British tradition, endorsed by appeals to its developmental advantages (Smith, 1994); yet some children would prefer not to face its dangers. Physical education (PE) in the curriculum has been fought for and established over the years, and is now a 'foundation' subject in the National Curriculum, but it is battling for time and space against the 'core' subjects: literacy, numeracy and science. Adequate space and equipment for exercise is shaped by national and local financial considerations. Individual teacher enthusiasm for exercise, as we describe in our case-studies, can powerfully affect children's experience.

The care children get at school is one of the main topics of this book, and again the character and quality of care results from a complex web of intersecting interests. Primary school staffs hold to the belief that they care for the whole child, and are child-centred — even nowadays. Many primary school teachers regard themselves, at least when they start on their careers, as carers as well as educators (Burgess and Carter, 1992). And at primary schools, which are largely staffed by women, caring work — for instance, when children fall ill — is added onto the educative and supervisory work for which they are paid. The lay health-care system of the school is operated by both teachers and non-teachers, with the secretary and dinner ladies commonly regarded as the main sources of help. Caring, the 'natural' work of women (Graham, 1983), is also endorsed through the *in loco parentis* principle. In taking children compulsorily into the 'care' of the education service each day, school staff argue that they must deliver care to the whole child. This view can also be justified on instrumental grounds: unhealthy children will not learn and state resources will be wasted (cf. Finch, 1984, pp. 75–9). Yet at the level of policies for the provision of education, recognition of the caring functions of school, for instance through the provision of first aid rooms, training of staff, or allocations of time for caring work, is patchy and dependent on local initiative rather than on formal requirements.

Of critical importance in determining the character of schools as health-related institutions is the separation of responsibility for health and for education at all levels of our society. The Department of Health and the Department of for Education are not renowned for communicating with each other (Audit Commission, 1994). At policy level, school health services are designed without consultation with education services, although liaison is urged in policy reports — for instance, a recent one on services for school-age children (BPA, 1995). At local service level, arrangements for consultation and coordination are lacking. At school level, as we shall show, liaison between the school health service and school staff is generally informal and dependent on individual initiative.

This division between education and health services encourages the idea that they are separate topics. That idea is commonly accepted as the basis for research on schools — which, in turn, reinforces the division. In general, research has focused on topics of psychological and sociological interest within the framework of the school as an academic institution. It is children's minds that are of interest, not their bodies or relationships between bodies and minds. Work has been on academic achievement, and factors affecting it; and on the social order of the school, focusing on the development of children's relationships with each other and with staff. The theoretical starting points underlying such work are the psychology of child development, or the sociology of peer and intergenerational relationships. Work on the functions and working of the school health service has been conducted almost exclusively by doctors, working within medical models; as exemplified in the references cited in the BPA report (1995).

The work towards this book began with a small-scale, intensive study in one school, where one of us, Berry Mayall, spent two terms as a general helper around the classroom, and talked informally and in more formal discussion sessions with children (aged five and nine), parents, teachers and other staff (Mayall, 1994a). The study explored the idea of the school, compared to the home, as a health-related environment. This work raised a number of issues which we have pursued using both a large-scale survey and six case-studies.

We have started from concern with children's embodied and emotional experience in the world of school, with a particular emphasis on the maintenance, promotion and restoration of health. Thus we aim to explore intersections of health and education; and this we do through studying both children's experiences, and policies and practices within and across health and education; the policies and practices form a framework for children's experiences.

We are concerned with issues of control over daily health-related care; how far children can and may look after themselves at school. Children arrive at school, aged five, experienced in looking after their health, under their mothers' care, guidance and control, and through continuous negotiation with their mothers. By five, children take some responsibility for health-related actions within that maternal framework (Mayall, 1994a, Chapter 2). At school, health maintenance takes place under a different set of conditions, within the context of educational agendas, pressure of time and place, and child–staff relationships. Whilst staff may be kindly, they do not offer a close relationship with children — which is the basis on which young children have, up to that point, negotiated health. Teacher remit, as understood by most teachers, and the demands of the education system, underwrites a more distant, but equitable teacher–child relationship. On the face of it, children at school are very much under adult control, which prescribes use of time and space all day long. If children are asked to behave responsibly about their health, as suggested in health education messages, then the extent of their freedom to choose and to control their environment are critical issues at stake. 'Responsibility' itself may take on a school-defined meaning, and refer to conformity with school norms rather than informed choice.

School staff are not free to pay full attention to children's interests. They have to serve other interests, notably those of the government, governors and, possibly, parents. But schools, whilst treating children as objects of the state exercise, may also simultaneously aim for respecting the children they serve. Bearing in mind the principles set out in the United Nations Convention on the Rights of the Child, we ask, to what extent do schools uphold children's rights to express opinions and to have their opinions taken into account in matters affecting them? (Article 12); and do actions within the education system take full account of their best interests? (Article 3). (For text of UN Convention see Children's Rights Development Unit, 1994)

This book, then, is innovative. Through its focus on the children's interests, it seeks to open up for discussion some taken-for-granted features of the primary school system. We do not have final answers, but we do explore questions. What are the relationships between the physical and social conditions of our schools and children's health-related experiences? How satisfactory are the opportunities children have at school for exercise and nutrition — which for them are the keys to good health? How well does the lay health-care system of the school work, in terms of children's experience of it? These questions are important both for understanding children's experiences and responses to school; and for considering how schools can be changed to provide health-promoting environments for children. In seeking to study such questions, we have sought to provide large-scale data, and information and views from staff at schools, as a framework for considering the children's own accounts.

The book is also timely. Primary schools are changing before our eyes. The principal changes relevant to the concerns of this book include: the introduction of the National Curriculum, the implementation of local (financial) management of schools (LMS), and the increasing stringency of budgets available for schools. The National Curriculum (introduced through the Education Act 1988) has required teachers to rethink teaching methods and allocation of time, in order to teach specified topics and reach specified targets; and one issue here is whether child-centred methods and ideals are currently appropriate. Another is whether children's experience of the school day is changing; for instance, do they think they work too hard for too long?; and is physical exercise being demoted in the face of the core topics? LMS has been widely welcomed by schools because it gives them power over decisions; our case-studies show that schools can now quickly introduce innovations to suit their own specific circumstances — such as, paying for extra adult help, or building an adventure playground. But LMS has been combined with increasing central government stringency on budgets, and child–teacher ratios and sheer class size have become media issues in the 1990s.

There has been a mounting chorus of interest and concern about these changes and their impact on children. As ever, in matters relating to schooling in the UK, the main concern has been about the academic achievement of children in the face of policy changes. But it is interesting that in recent months (late 1995) public concern is encompassing the wider interests of children, beyond the simply academic. There have been reports of crumbling and dangerous buildings (*Guardian*, 5 December 1995). A recent article was about the impact of over-crowding on children's mobility in class (*Guardian*, 24 October 1995); the point made was not just that unhealthy conditions are linked to poor 'academic performance', but that unhealthy conditions are undesirable in themselves.

Themes of the Book

The principal themes of the book are in line with the points made so far. Overall, the theme is the status of children's health within primary schools. We are studying what and how services, traditions, policies and individuals, intersect to constitute an understanding among adults of what attention should be given to children's health at school. Since, as we believe, adequate health maintenance requires some control over one's actions, we explore children's rights within education. An important focus of this exploration is children's own views of the status of their health at school. Do they feel respected as embodied actors, or downgraded to the status of pawns in the adults' games with targets and assessments?

Within this overarching theme, we consider the intersections and interactions of agency and structure. Some of this is a literal concern for the ways in which children, as social actors, experience the physical environment, the buildings and playspace where they are required to spend their days. We are also interested in what school staff have done to alter and improve the physical environment. There is a more metaphorical side to this theme: how far do individual people, children and adults, work within or in tension with the social order of the school?; are staff views and behaviour congruent with the order they both work in and construct?; and how satisfactory is the adult-controlled social order for the children — can they negotiate more satisfactory conditions and experiences?

As suggested above, a central theme is the division of labour between the various parties to the schooling of children. By that we mean, where does responsibility lie and how is it shared; what is the division of the work and, again, how much scope for negotiation is there? Topics here are: the organization of health-care work between teaching and non-teaching staff; the care of children who have accidents or claim to be ill; the nutrition of children at school; the contribution of the school health service; the organization and delivery of health education. These divisions of labour are considered in terms, not just of the adults involved, but of the children themselves. We explore what part they play in health-related work, what responsibilities they do or do not take, in relation to those taken by adults, and how much scope for negotiation they have.

Running through the whole book is an interest in children's and adults' ideas about what children are and what childhood should be. Here we are concerned with the impact of adult ideas on the social regime they propose for children. As with every aspect of primary schools, there are many intertwined themes here. Thus adults generally assume that adults know best what children should do at school, in terms of what they should learn; and the specificity of National Curriculum topics may reinforce that view. Yet some cross-curricular topics in the National Curriculum may encourage adults to engage on more equal terms with children, as active learners about the environment, and as contributors, through personal and health promotion sessions, to improving the social order of the school. Adults also construct ideas about and implement policies on how the curriculum should be delivered; whole class teaching may be endorsed theoretically as well as in response to large classes. Even the child-centred regime is based on adult views of children's 'needs', 'developmental stage' and 'readiness' (Walkerdine, 1984, 1990; Mayall, 1996: Chapter 4). Children may be regarded, variously or in combination, as fodder for the state, as empty vessels, as projects for civilizing, as active participants in the enterprise of learning, as products of parental behaviour or as victims or threats to the social order. We know little about children's views of their own childhoods or of childhood more generally. One purpose of this book is to increase our understanding of children's experiences of childhood, as lived at school. We shall suggest that as a social group they have distinctive 'takes' on those experiences, as compared to adult views of how children should experience school life.

The Order of Events

The book is based on a study entitled 'Health in Primary Schools', funded by the ESRC from July 1993 to December 1995. The first part of this book reports on the first stage of the study: a survey in the autumn term 1993, using a postal questionnaire, of primary schools in England and Wales. This survey targeted a one in twenty sample of schools, stratified by local education authority, in order to represent all parts of the country. Of the 1031 schools approached, 620 (60 per cent) replied, and their replies provide a representative sample of schools. We report on the condition of our schools: the numbers of children and staff, and the characteristics of the building and playspace. The survey report goes on to consider factors relating to health maintenance in the 620 schools: exercise and play; policies and practices on food at school; health education policies; health promotion more generally; the lay health-care system as regards illness and accident; and the input of the school health service to schools.

The second stage of our study was a set of six case-studies, discussed in

Part Two. We named the schools City, County, North, Infant, Town and Village (see p. 86). Members of the research team spent about a month in each school collecting data on the same set of topics, through interviews with staff and children, and some parents. Each of the six case-studies gives a picture of what turned out to be highly individual schools, and explores our principal themes for that school. Following these six case-studies, we devote Part Three to the children's understandings and experiences, bringing together the data collected with them, across the six schools. This section provides a counterbalance to the adult accounts, and is a unique perspective on daily life at school. The book ends with a discussion of the data in the light of our themes. We have distributed drawings by the children throughout the book, as a graphic reminder of their perspectives.

Part 1

The Survey

1 The Survey

This part of the book details and discusses the results from the first stage of the project, the survey data collected by a postal questionnaire in the autumn of 1993. The questionnaire was sent to 1031 schools, a one in twenty sample of the approximately 20,000 schools listed in the Primary Education Directory 1993 and representing each LEA in England and Wales. Questionnaires were sent out at the beginning of November 1993 and were addressed to the headteacher. The total number of replies was 620, giving an overall response rate of 60 per cent, (61 per cent from England, 52 per cent from Wales). Although the response rate varied by LEA, the sample included schools from all parts of England and Wales. When compared with data from other sources, the survey schools are seen to be broadly representative of primary schools in England and Wales with regard to age-range, size of school, and denominational status.

The questionnaire covered aspects of the physical environment, health education, health maintenance, issues relating to food and exercise, how accidents and illness were dealt with by the school and the role of the school health service. The questionnaire also invited respondents to comment on the particular strengths and weaknesses of their school and over three-quarters of respondents provided these additional comments. (For more detail of the method, and the questionnaire, see Appendix 1.) In all the tables shown, 'N' denotes the base number used to calculate percentages.

The Schools: Environments and People

The first base-line set of topics we aimed to describe concerned the type of area served by the school, the age-range, the numbers of children and staff–child ratios. These topics are the ones we found most useful for analysis purposes, to identify differences between schools.

Location

We asked about the type of geographical catchment area the schools served, using categories of inner city, city, large town, small town and rural.

Table 1.1 Location of survey schools (%)

Inner-city	*City*	*Large Town*	*Small Town*	*Rural*	*N*
11	11	20	32	26	605

For purposes of analysis, in most cases, we have put together City and Large Town. So our sample fell into four categories, described as inner-city, city (31 per cent), town and rural.

In selecting our case-study schools, area was one factor. The final choice included an inner-city school (City), two schools in large town areas (County and Town), a school in a small town (North), one in a rural area (Village), and another sited rurally between two villages (Infant).

Age-range

Most schools catered for the whole primary age-range (4/5–10/11 years). A quarter dealt with the lower age-range of between 4 and 5 and up to 7, 8 or 9. However 12 per cent were junior (7–11) and a further 2 per cent (10) were middle schools (8–12/13). For analysis purposes the junior and middle schools, which cater for the older section of the age-range, have been put together. Three main categories have been devised from the data:

Table 1.2 Age-range of survey schools (%)

Primary — children enter aged 4/5 and leave at 11 (61 per cent)
Infant — children enter aged 4/5 and leave at 7, 8, sometimes 9 (25 per cent)
Junior — children enter aged 7/8 and leave at 10/11 or at 12/13 (14 per cent)

Although this study is concerned only with school-age children, we asked, for descriptive purposes, whether schools had a nursery class. Overall, 27 per cent of the survey schools had at least one nursery class. These were less common in rural schools, where only 13 per cent reported a nursery class compared with 53 per cent of the inner-city schools.

Our case-study schools included three primary schools (City, Town and Village) an infant school (Infant), and two junior schools — North and County (the latter had until recently been a middle school).

Number of Children

The survey schools ranged widely in size from 7 through to 600 children.

Table 1.3 Numbers of children in survey schools (%)

under 100	*100–199*	*200–299*	*300+*	*N*
18	30	35	16	575

There were marked differences in numbers according to the location of school. Thus 52 per cent of rural schools had fewer than 100 pupils compared to only 8 per cent of inner-city schools. Whereas 27 per cent of inner-city and 31 per cent of city schools had over 300 children, only 4 per cent of the rural schools were this large. (See Table A2.1, p. 241.)

Virtually all the survey schools (99 per cent, or all but six) were mixed and 98 per cent were maintained schools. By denomination, 66 per cent were non-denominational, 24 per cent were Church of England, 9 per cent were Roman Catholic and 1 per cent were of other denominations — two nonconformist (United Congregational) and three Church of Wales.

One of the topics we wished to pursue in more detail in the case-studies was relationships between the size of the school and the health-care systems in place. So numbers of children was one factor determining our choice of case-study schools. Village had just over 100, and Infant 150 children. Town, City and North had over 300, and County, the largest, had over 500 children.

Staff–Child Ratios

Just as we shall see that sheer numbers of children in the school affects many aspects of the service offered, so too adult–child ratios are critical. The ratio of adults to children in school is one indication of the schools' ability to give the children good care. We asked for numbers of teaching staff (full-time or part-time) and numbers of non-teaching staff. In order to keep the questionnaire manageable for respondents, and in order to maximize responses, we enquired only about numbers of adults, not about what proportion of a full-time job they did. Consequently, the data on staff–child ratios must be treated with some caution, since we count here all adults on the staff, not full-time equivalents. However, we also know from our case-studies that many part-timers habitually spend longer hours on the premises. Probably, the broad picture is representative of staff–child ratios. The full break-down is given in Table A2.2, p. 242.

Generally, as might be expected, the smaller the school, the better the teacher–child ratio; of schools with fewer than 100 children 48 per cent had under fifteen children per teacher, compared to 9 per cent of schools with 100+ children, and 2 per cent of those with 200+ children. The majority of schools with over 100 children had a ratio of twenty to twenty-four children per teacher: 50 per cent of schools with 100+ and 57 per cent of schools with 200+ children. In the biggest schools, ratios were the highest: 23 per cent of schools with over 300 children had a ratio of twenty-five or more children per teacher.

By location, rural schools had the lowest ratios, and inner-city and city schools had lower ratios than schools in the large and small towns. Presumably rural schools have fewer children in each age band. One explanation for the favourable city ratios is higher allocation of staff for special needs children, and for linguistic minority children, as indeed we found at City school.

We asked about other staff: all paid non-teaching staff, including secretaries, caretakers, classroom helpers, playground and dinner supervisors, special needs support. Again, this was a head count, rather than a full-time equivalent (FTE) count. Table A2.2 shows that on this basis the most favourable ratios were reported from rural schools.

In line with our interest in how many adults overall were available to take a share in caring for the children, we put together all teaching and non-teaching staff in order to consider staff–child ratios:

Table 1.4 All staff–child ratios in survey schools (%)

		Number of children per staff member			
1–7	*8–9*	*10–11*	*12–13*	*14+*	*N*
19	24	26	18	12	570

It can be seen that children's opportunities for contact with staff varied widely, with 19 per cent of children competing with up to six others, and 12 per cent at the other extreme competing with 13 or more.

Location was important and the most striking percentages are consistent with the points made above. Rural children did best: two-thirds reported ratios of up to nine children per adult, with 40 per cent reporting ratios of 1–7. Almost half the inner-city schools also reported nine or fewer children per adult.

Finally, on this front, we looked at all staff–child ratios by the size of the school. This confirms the point that the smaller the school the better a child's chances of adult attention; 70 per cent of schools with under 100 children had one member of staff to a maximum of seven children. This favourable ratio was current in only 19 per cent of schools with 100–199 children and only 1 per cent of those with more than 200 children. At the other end of the scale, only 1 per cent of the smaller schools had fourteen or more children per adult, but in 20 per cent of the largest schools, this was the situation.

We enquired whether respondents thought the school was well staffed in terms of numbers and types of staff, as regards the maintenance and promotion of children's health. Generally, schools were positive on both counts, with 70 per cent and 76 per cent respectively reporting their staffing as good. Only 7 per cent gave a poor rating for numbers of staff, and only 2 per cent a poor rating for types of staff. There were no significant differences by the size of the school. But staff–child ratios were significantly lower in those reporting their staffing as very good (mean 9.6:1) compared with those reporting it as poor or very poor (12.1:1). Since 1993–94 when the survey took place, there has been very great media concern about rising class sizes. For instance a *Guardian* report (25 October 1995) reported 7.4 per cent and 11 per cent rises in classes of thirty-one or more and thirty-six or more respectively for the year 1995–96.

However, it was generally the case that respondents praised the school and the staff as providing a caring environment for the children. It is almost axiomatic that staff regard this as a central function of primary school. Thus in the last section of the questionnaire, where we invited comments on the strengths of the school, the principal topic mentioned — 40 per cent of comments — was the caring and committed staff:

> Caring staff who make the best of the situation.
>
> Just a caring environment, which we constantly promote.

Unpaid Help

In addition to paid staff, we asked whether schools received any regular unpaid help, under four categories: classroom work, school trips, swimming and any other help. Most schools reported some unpaid help in the classroom (88 per cent) and on school trips (87 per cent); fewer (57 per cent) reported help with swimming and 30 per cent reported a wide range of other regular unpaid help, mainly with cookery, craft and the library, but also with fundraising, administration, DIY and building maintenance. A minority (20 per cent) of schools reported help in all four categories, 41 per cent recorded three and 26 per cent two categories. Eight per cent reported help in only one area and 6 per cent either had no help or missed the question.

It is consistent with these findings that those schools with a parents' organization were more likely to have unpaid help in the school. Most schools (84 per cent) reported a Parent Teacher Association (PTA) or similar association. Slightly higher proportions of Church of England schools (90 per cent) had PTAs, compared to 82 per cent of non-denominational and 79 per cent of the Roman Catholic schools. In total, 22 per cent of schools with a parents' association (but only 8 per cent of other schools) were getting regular unpaid help with all four tasks. By denomination, the Church of England schools reported slightly more help than the other denominational or non-denominational schools; 26 per cent reported help in all four categories.

Comments

This section has described some important aspects of the wide range of circumstances in which children spend their days in primary school. Schools across England and Wales, sited in a range of locations, varied widely in the numbers of children, in the age-range children would meet and live with, and in the chances children had of adult attention. The extent to which schools can get help from parents and other local people also varies and, as our case-studies suggest, there are many relevant factors: for instance, the strength of the local community (as at Village); the social and psychological damage suffered by parents in areas of high unemployment (North); the recognition by the school of the need to use a range of ways of attracting parents from a range of ethnic cultures (City); the extent to which local people are willing and able to help the school financially as well as socially (County). The data reported on in this section is, unfortunately, rather loaded with numbers and numerical comparisons. We have given the information in some detail in order to point to the range and, ultimately, inequalities of children's experience at school.

2 The School Buildings and Playspace

Comments made by schools about their physical environment painted some starkly contrasting images:

> We have a beautiful building and a very calm safe environment. We have a little wood, a playing field and a wild garden as well as a playground. All our equipment is new and up to date. (Post-1965 city primary school with 200 pupils)
>
> It is old, damp and has restricted space both within classrooms and in terms of playground space. Apart from playground markings there is no play equipment in the playground. (Pre-1875 town primary with 180 pupils)

Perhaps the most striking feature of the primary school as a context for children's daily life is the huge range in the character and quality of the buildings and playspace.

Age and Type of School Building

We were interested in how staff assessed the school building as a health-related environment for the children and we tried to identify the character of the building by asking about its age and type. The answers probably give a broad picture of character, although, as respondents noted, many schools had grown 'organically' and comprised a range of buildings dating from different periods. As one small town school in the south-west writes:

> The school buildings have been 'knocked through' over the last 50 years to provide access and accommodation as the school has expanded. The internal layout has to be seen to be believed.

In asking about the age of the school building, we offered respondents the categories used in earlier reports (e.g., DES, 1967), so that comparison between our study and earlier ones could be made (see Table A2.1, p. 241). In this study, school buildings ranged in age as follows:

Table 1.5 Age of school buildings (%)

pre-1903	*1903–44*	*1944–65*	*post-1965*	*N*
30	13	15	42	590

Many rural schools were housed in the oldest buildings (56 per cent), as were Church of England schools (53 per cent) and small schools with under 100 children (70 per cent). Fewer junior schools (17 per cent compared to 27 per cent infant, 33 per cent primary) were in older buildings. In contrast, Roman Catholic schools were frequently in modern buildings; 57 per cent were in post-1965 buildings, compared to 40 per cent Church of England, and 40 per cent non-denominational. The larger schools were more commonly in modern buildings: 51 per cent of those with over 200 pupils were built since 1965.

Asked about the type or style of building, 60 per cent of respondents described the buildings as 'modern', 18 per cent as 'old school house', 10 per cent as 'Victorian' and 3 per cent as 'prefab'. The remainder, 8 per cent (mainly schools of the 1903–44 period) defied our groupings and were returned as 'other'; for instance: 'a 1933 temporary wooden building, now providing poor accommodation with rooms reaching 90 degrees on hot days.'

Not surprisingly, 40 per cent of rural schools were classified as 'old school house' compared to only 5 per cent of inner-city schools and 8 per cent of city/large town schools. And 20 per cent of inner-city schools were described as Victorian two-storey (or more) structures. Over 70 per cent of large town and city schools were 'modern' compared to 60 per cent of inner-city schools but only 40 per cent of rural schools. (See Table A2.3, p. 243.)

Age seemed to be easier to assess than building type; 590 schools responded on age, compared to 527 on type. For this reason, we have generally used the age of the school building in our subsequent analyses.

The General Environment of Schools and Child Health Maintenance

We asked respondents to rate the physical aspects of the school: the building and the outside space as environments for the maintenance and promotion of good child health.

As Table 1.6 shows, the building itself and the toilets attracted most of the unfavourable ratings, with over a fifth of schools rating them poor. However, perhaps because classrooms are easier to improve, nearly two-thirds of respondents gave them high ratings. Over 60 per cent rated the heating of the school as good or very good, but there was more dissatisfaction with ventilation systems.

Table 1.6 also shows that levels of satisfaction with the building, classrooms, toilets, heating and ventilation were consistently much higher in newer schools. However over a fifth of the oldest buildings were rated as good, and 8 per cent of the most recently built schools as poor. One of the latter describes itself as 'a flat-roofed, leaky, overcrowded, unfinished 1979 disaster'. The complexity of relationships between age and quality of the building is mirrored in our case-studies, where City had an old, but spacious, solid 'good' building, Village had an even older and unsatisfactory building; County had a

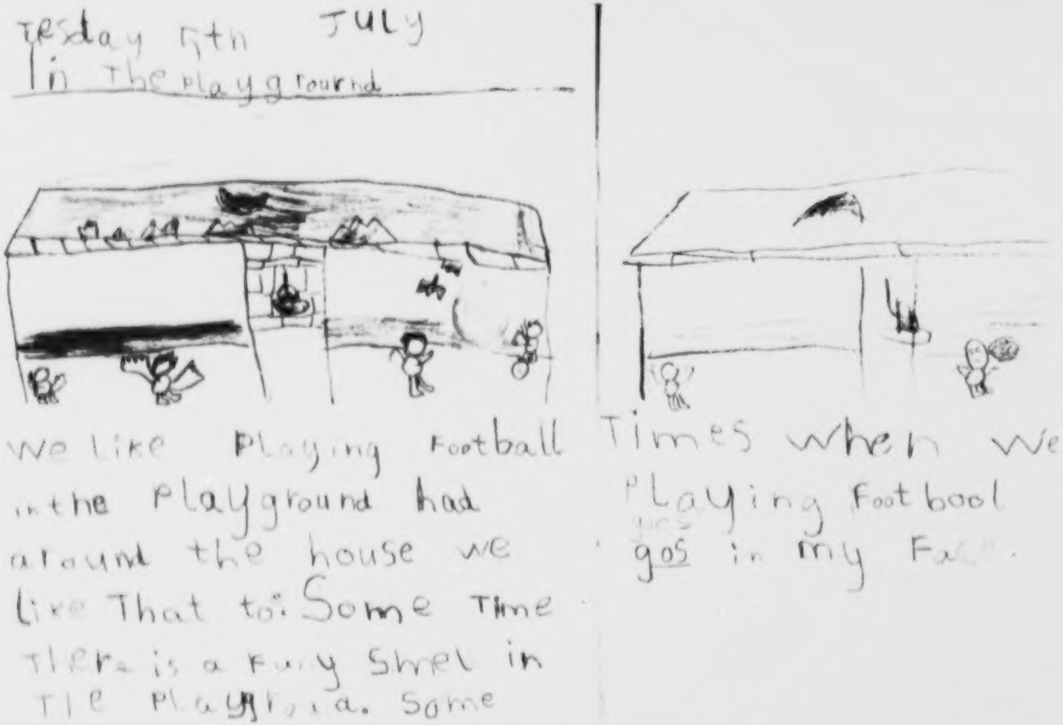
Tesday 5th July
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Figure 1.1 In the playground: 'We like playing football in the playground and around the house we like that too. Sometimes there is a funny smell in the playground. Sometimes when we are playing the football goes in my face.'

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Table 1.6 Satisfaction with aspects of school environment by age of building (%)

	Age of school building				
	Pre-1903	1903–44	1944–65	Post-1965	All schools
Rating of building					
Very good/good	21	30	44	55	39
Average	44	39	36	37	39
Poor/very poor	36	31	20	8	22
Rating of classrooms					
Very good/good	54	51	69	73	64
Average	34	30	26	22	27
Poor/very poor	12	19	5	5	9
Rating of toilets					
Very good/good	39	44	45	55	48
Average	31	33	33	30	31
Poor/very poor	30	23	22	15	21
Rating of heating					
Very good/good	51	65	67	65	62
Average	36	25	24	27	29
Poor/very poor	13	10	9	8	9
Rating of ventilation					
Very good/good	45	53	67	62	56
Average	35	31	23	28	30
Poor/very poor	20	16	10	10	14
N	174	79	90	247	590

1960s 'poor' structure, but Town, built at the same time, was regarded as well built.

In general, older schools called forth more adverse comments. This rural primary school in an old school house, with just over a hundred pupils, operated in totally unsuitable surroundings — as did our Village case-study school:

> Buildings are all separate. Insufficient playground space for numbers on roll. Outside toilets. Poor ventilation in old buildings. Inadequate insulation in new prefab-type buildings.

A west country school describes a dire situation. It was situated on a split site with a busy public road running through it which caused worries about pupil road safety. Staff wished to move from the damp, cold, sunless old building to the main school site opposite; to demolish the temporary classrooms constructed over forty years ago and literally falling apart and move to the modern brick-built building with indoor toilets and a modern centrally heated system; to have a proper dining hall — not the daily movement of desks for meals. In summary, the respondent notes:

> It is clear that the school buildings do not comply with health and safety regulations. If this was a private firm they would have closed this place long ago.

But other aspects of the physical environment of the school were listed as strengths:

> Excellent playground/field facilities for (the) small number of children we have. Trees, pond area and marvellous field and swimming pool built by the parents.

The health and safety theme was also directly addressed by a town junior school, built before 1944. Priorities for improvement were:

> Better heating system (present one blows dust around and very inefficient). Upgrade toilets. Have toilet areas closed off from classrooms (at present, each class has two toilets in cloakroom areas, not closed off from classroom). Lack of money is our LEA's main problem. They are concerned. Because our school is open-plan and has an inefficient heating system we are often cold. Also the fan heaters blow dust out and cause throat and chest problems in some children.

Although the survey did not specifically address the changes in use and numbers of children that school buildings are expected to accommodate over time, many comments highlighted overcrowding as an important current problem. Buildings which were designed for smaller numbers were now under stress from rising rolls.

> Classrooms too small for classes of 30 children [DfE standard, now rescinded, was 25 per room]. Two huts for classrooms with no water/toilets. (Large town infant school)
>
> . . . because of an increase in roll numbers, we require a fourth teaching area with toilet facilities. We are presently using a kitchen and library area. (Rural infant school in old school house with under 100 children)

Overcrowding, interestingly, was not an important topic in Plowden (DES, 1967) or the National Union of Teachers' 1962 study (NUT, 1963); they were more concerned with the quality of buildings and equipment. But it was in the 1976 survey (DES/Welsh Office, 1977). It would appear to be a growing problem. We pursue the issue in the six case-studies; it has particular importance for children's well-being in school, and may relate to accidents in the playground and in the building.

Heating and ventilation attracted adverse comments from schools of all ages. One modern school reported 'an antiquated heating system which frequently breaks down, is noisy and occasionally fills the rooms with fumes'; another comments on 'poor heating and excellent ventilation due to ill-fitting windows'.

Schools in general make the best of what they have. Respondents were loyal to their staff. Fewer than 10 per cent rated the cleaning and caretaking of their school as poor or very poor, and two-thirds described them as good or very good. Schools recognized the commitment of the cleaners and caretakers to make the best of the poor buildings and several pinpointed this work as a strength of the school. For example, one praised 'caretaking standards of cleaning — not easy considering age of building and situation of school on main trunk road'; and another succinctly noted: 'The toilet facilities are a well-maintained [by the caretaker] disgrace.'

When asked to list priorities for effecting improvements to the school environment, 26 per cent of schools mentioned some aspect of the building which needed attention and 16 per cent identified the lavatories as a priority. We did not ask specifically about outside lavatories but fourteen schools mentioned their outside toilets as a particular weakness or as an area for improvement in the school.

Some respondents were clearly faced with insuperable odds:

> Outer doors — LEA responsibility should have a higher standard of closures. School has been left with a legacy of ancient flooring to maintain and upgrade. Rewiring needed. Plugs are sited near sinks. Poor quality flooring — lino cracking and coming away from floors. Worn carpets — poor siting of electrical outlets. No lighting in the evening — vulnerable to vandalism burglary. LMS has helped the school address issues of poor maintenance of buildings. Decoration, fixtures and fittings. However the legacy of previous poor maintenance by LEA means it will take some years before a rolling programme can be completed e.g., school decorated and furnished and a medical room.

Few schools suggested such drastic solutions as this inner-city infant school:

> ... demolish and build a new school for the seven classes. The current accommodation, built in 1921 of prefabricated asbestos and extended with mobile classrooms, houses over 250 pupils. A full condition survey of the building recommended spending no more money on it because it was past saving. The school leaks, has rusting windows, rotting timbers and suffers with blocked drains.

Playground and Play Equipment

As with the building, so with outside space and equipment: there was a wide range of ratings. Over half the schools rated their playgrounds as good, with under a fifth rating them as poor. The biggest area of concern was with play equipment, with 44 per cent giving a rating of poor or very poor. On the whole, playground and play equipment were rated as similar in quality: that is, 39 per cent rated both playground and equipment as average or good, whilst 32 per cent rated them as average or poor. However, 15 per cent rated their playground as good or very good but equipment as poor or very poor. In contrast, only 1 per cent rated the playground as poor and the equipment as good.

Table 1.7 Satisfaction with aspects of play environment by age of school building (%)

	Age of school building				
	Pre-1903	1903–44	1944–65	Post-1965	All schools
Rating of playground					
Very good/good	43	41	55	61	52
Average	30	33	26	29	30
Poor/very poor	26	26	18	10	18
Rating of playground equipment					
Very good/good	19	20	25	30	24
Average	29	33	28	35	32
Poor/very poor	52	47	47	36	44
N	174	79	90	247	590

Again, when these ratings are broken down by the age of the school, a varied picture emerges. Table 1.7 indicates that many playgrounds in more modern schools were highly rated (61 per cent), and pre-1944 schools had more of the lower ratings. We expected there would be differences between rural and more urban schools in ratings of the play environment. Indeed 60 per cent of the rural schools rated their playgrounds as very good or good; with somewhat lower percentages for town schools (52 per cent) and for inner-city and city schools (49 per cent).

But not all rural schools have plenty of space. Several commented about playing fields which could not be used in winter because of poor drainage and some had no field. A small rural primary school reported its hopes:

> to obtain use of school field near to school. At present quarter of a mile away. No school playing field or hall or indoor PE facilities.

The low ratings of the quality of playground equipment were striking, and may reflect current budgetary constraints, and perhaps rising expectations about what should be provided. It was the oldest schools which reported the worst conditions, suggesting poorer base-line equipment. However, there was little reported difference by the location of schools: 26 per cent of inner-city schools and 23 per cent of rural schools rated their playground equipment as good.

Improvement to playgrounds and play equipment seemed important in many schools. Asked about priorities for improving the school environment, 37 per cent of schools described plans for the playground or play equipment.

improving hard surfaces, more markings for games, creation of seating, grassed and quiet areas as well as the purchase of new equipment. This attention to the outside playspace may be in part a reflection of the new emphasis in the National Curriculum on environmental education. It was clear that a great deal of planning and thought had gone into these schemes. One town school reported plans to create a garden and play area when it had demolished the air raid shelter! An example of the detailed comments given is:

> Insufficient equipment for what could be excellent grounds — we are already working on this. Alterations to playground to provide a variety of play areas and activities. Resurfacing of playground. Division of field into smaller areas of interest. Greater variety of plant life etc. to be provided. Fencing off of small play area so 4-year-old children [new entrants] have their own area for play. (Town infant school)

The data suggest that almost all schools were doing something to improve this aspect of its environment. Many schools cited parental input or assistance from other sources.

> Extensive work is beginning to take place regarding the children's external environment complete revamping of hard and soft play areas in conjunction with landscape architect, Rural Action and parents. (Rural primary school)
>
> PTA [is] raising funds to build extra playground. PTA have decorated the new classrooms school have provided.

Overall Assessment of the Physical Environment

It is interesting, and also disheartening, that many of the features of primary schools described — and many of the assessments by the respondents — are familiar from earlier reports. These include the NUT (1963) survey, the Plowden Report (1967) and the DES Welsh Office *A Study of School Building* (1977). Critical issues and problems cited then continue to be salient here. Thus considerable proportions of schools (30 per cent) continue to be housed in pre-twentieth-century buildings, and these buildings and their playgrounds attract particularly high rates of concern in the reports, and in this survey, as environments for children's daily lives.

The need for improvement to the physical environment, which runs through the earlier reports, continues as a current concern, judging by our respondents. The school lavatories may increasingly be inside rather than outside (in 1963 only 28 per cent of primary schools had all lavatories inside the main building, according to the NUT survey; in 1967, Plowden reported that at 65 per cent of schools they were outside the main building), but they still give rise to dissatisfaction. Play equipment is another important issue: it was rated as poor in 44 per cent of cases in our study. The 1976 survey does not deal directly with equipment but notes that 'few pre-war primary or secondary schools have welcoming sites; in urban areas few have anything but hard asphalt surfaces surrounding them' (DES/Welsh Office, 1977, para. 5.64). However, it seems that the buildings and improvement programmes undertaken in the post-war period (Maclure, 1984) offered better standards, or at least standards approved of by schools nowadays, since it was consistently the newer schools that rated various physical features of the school as good.

To obtain an overall assessment of how each school rated the physical environment it provided for children we developed an index which incorporated respondents' ratings on the following factors: classrooms, toilets, heating, ventilation, cleaning, playground and playground equipment, input by the LEA; and whether the LEA had given help (see Appendix 3). The index enabled us to study in more detail schools with high and low scores. The age of the building appears as a significant factor, with post-1965 buildings scoring the highest, and late nineteenth century (1875–1903) the lowest (Table A3.1, p. 245). However by location, there are further points. Rural and inner-city schools did not differ significantly according to age of building on this index. But city, large and small town schools did: those built in the pre-1903 period score lowest, those post-1965 the highest.

It may be that some inner-city older buildings (like City) were serving current usages well, and some, but not all, rural schools offered mixed character but versatile accommodation too. In addition, some inner-city schools may attract larger budgets — and can modify the environment; LEA input to rural schools may be particularly variable across authorities.

This city primary school was one of the poor scorers on this index. It had 250 children in eleven classes, and was built between 1903 and 1944. Our respondent described:

> Cold and dampness in many classrooms, plus unheated corridors therefore rapid changes in temperature encountered as children go from classroom to corridor and back to classroom are seen as the particular weaknesses of the school for the health of the pupils. Plans for improvement include removal of flagging in outdoor areas where subsidence has caused tripping hazards, replacement of heaters (cost permitting, therefore very long term) and the removal of mould on walls following effective eradication of cause of dampness (cost permitting). However, the delegation of funding and therefore responsibilities to schools means that the school is unable to address health and safety issues connected with school environment, to date, because of inadequate funding. LEA has provided some health and safety education training and guidance.

This northern inner-city school, built post-war, but before 1966, suffered not only from the poor fabric of the building but also because 'the playgrounds are open to the general public and are used as a thoroughfare.' Fencing the play grounds — 'to keep off intruders and dogs' — is listed as a proposed improvement to provide safer, more interesting play areas. However, 'money is very limited for anything beyond basics'.

Among the schools with good indexes, one picked out some key factors which contributed to a healthy environment:

> Green field site and spacious classrooms in main school. En suite toilets. Dedicated and observant caretaker.

Others were managing to find the resources to improve facilities, with plans to upgrade heating and ventilation, or, like this school in the south-east, to improve the play areas:

> Major promotion of playground environment. Trees and shrubs to be planted. Equipment to be purchased over a period of time. Although a fairly modern school we have very limited space for resources.

This section of the report therefore raises for consideration the impact of people factors versus structural factors in constituting the school as a health-promoting environment for children. For instance, many rural children enjoy (or experience!) high staff–child ratios, but spend their days in relatively poor buildings. Children living in towns are fairly likely to attend larger schools in new buildings but may have fewer adults in their social environment. Social policies which give schools control of budgets (LMS) allow some to make dramatic improvement in the environment. Some schools with reasonable buildings are able to turn their attention to upgrading the play areas. But reductions in budgets coupled with LMS mean that some schools with poor physical environments cannot find the resources to make essential improvements and LEAs offer only limited help, as this school (built before 1903) reported: 'the LEA will not replace windows to allow for adequate ventilation because of the cost.' A recent report (April, 1996) documents 'an appalling level of neglect of the condition of our schools' (ACC and AMA, 1996).

3 Curricular Exercise and Play

Exercise and food are the main topics identified by children as health promoting, as this and other studies show (see The View from the Children, pp. 188–90). We have taken account of this identification in our case-studies, and pursued both topics in detail, through staff and children's accounts. In the survey, we aimed merely to set the scene on the complex matter of what is offered in schools, as regards exercise in the curriculum and at breaktimes. We asked schools to rate the standard of curriculum exercise and the opportunities for play.

Table 1.8 Satisfaction with opportunities for exercise and play by age of school building (%)

	Age of school building				
	Pre-1903	1903–44	1944–65	Post-1965	All schools
Rating of curricular exercise					
Very good/good	59	74	76	78	71
Average	34	22	22	21	25
Poor/very poor	7	4	2	1	4
Rating of play opportunities					
Very good/good	46	49	61	65	57
Average	38	39	32	30	33
Poor/very poor	16	12	7	5	10
N	174	79	90	247	590

Over 70 per cent rated curricular exercise as good, but only 57 per cent rated the opportunities for play that highly. It seems likely that respondents considered that the provision of curricular exercise/PE lay somewhat within the control of staff and this may account for higher ratings. Rating of both curricular exercise and play opportunities strongly reflected the ratings of the playground and the play equipment. As we have seen, some schools thought the playspace was inadequate in terms of space, safety and equipment. The provision of curricular exercise attracted much the highest ratings in the newest schools, which may reflect high evaluation of staff work in newer schools, some of which are large, and may have well-established, well-staffed curricula for PE, and also better physical space in some cases (such as a hall with gym equipment). A NUT 1962 survey found that assembly halls were rarer in older and in smaller schools; sole-use gyms were — as now — very rare in all types of primary school.

This village school in the south-west was particularly exercise-oriented and described its strength thus:

> The present Year 4 children have been following a fitness programme for four terms called 'Fitness with Bertie'. This term the Year 3 children also started this programme. The programme aims to develop an awareness of the importance of physical activity and good health. The emphasis is on the child competing with himself not others. The programme of exercise aims to develop strength, stamina and suppleness. It is very popular with the children, they find it a challenge and very enjoyable. At the moment we are not happy with the outdoor play facilities but plans have been made for a fitness trail and new playground markings early 1994. The development of a fitness trail for Years 2, 3, and 4. Improved playground markings for a variety of games/learning activities. Development of a self-contained outside play area for Reception and Year 1 children. Outdoor swimming pool — children swim everyday during the summer term (if weather is suitable). (Post-1965 rural primary school)

A number of other small, rural schools with poor inside space for exercise particularly mentioned how limited they were by the weather:

> No hall — therefore PE, games etc take place in the playground — weather permitting. (Post-1965 rural infant school with thirty-two children)

> Excellent outdoor facilities in fine weather, good varied programme of PE activities . . . Lack of indoor space for activity (which is vital for this age group). (Pre-1903 rural primary school with seventy children)

However, others were enthusiastic about their initiatives:

> New PE apparatus in hall (lighter to carry, more challenging for reception/Year 1 children). Challenging PE work, including adventure playground. Developing PE indoor apparatus work outdoor adventurous activities. (Pre-1903 rural infant school)

This town primary school with over 200 pupils rated its old school house building, its playground and play equipment all poor but indicated how nevertheless it promoted exercise.

> We have a swimming pool on site. We run a lunchtime gymnastics club and sports club. We belong to a community sports scheme. Working on joint project with secondary school on same campus.

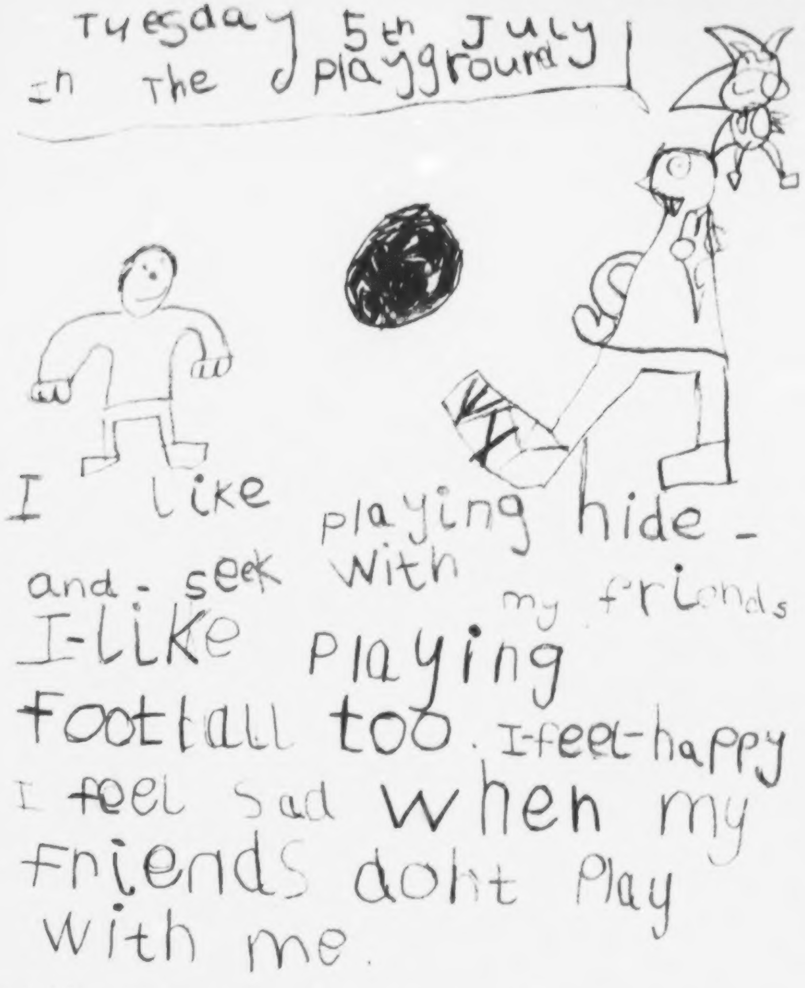
Tuesday 5th July
In The Playground
I like playing hide-and-seek with my friends
I-like Playing football too. I-feel-happy
I feel sad when my friends dont Play with me.

Figure 1.2: In the playground: 'I like playing hide-and-seek with my friends. I like playing football too. I feel happy. I feel sad when my friends don't play with me.'

Despite their attempts to encourage exercise, a number of schools commented that children were not getting sufficient exercise. For instance, a town primary school commented that:

> . . . too many children come to school by car. Despite all our PE and games many of the children are lethargic/tired and find exercise quite a strain.

From the children's point of view, PE and breaktime both offer a chance to play, to get exercise, and to spend time away from classroom work. Indeed PE as a feature of the school curriculum may have less allocated time than breaktimes. The Dearing Report recommended only one hour a week for PE for Key Stage 1; and a 1993 observational survey of inner London Year 2 classes found that children were doing 65 minutes a week of PE (Plewis and Veltman, 1995). Yet for infant classes, schools tend to have a morning and afternoon break, as well as dinner break — in all at least 90 minutes a day. And though junior classes often have only a morning break, this still gives them about 75 minutes playtime a day. It is said that schools are now being forced to compete with each other by reaching high standards in academic work. Given the pressures on schools to require children to spend more time sitting in class, and focusing on the core subjects, English, maths and science, it is of interest whether staff give higher or lower status, including time allocation, to PE. In our case-studies, some staff certainly did rate PE highly, and some specifically linked it in with science and health education. They thought it was important to provide children with opportunity to exercise as a counterbalance to the academic work of the school, and to teach children, through exercise, about how their bodies worked, and about interrelationships between exercise and health.

In the case-studies, therefore, we have explored with children the merits of both PE and playtime as features of their day, in the light of the physical and social constraints and opportunities children identify.

4 Accidents and Illness at School

Children have to be at school all day, and are in the care of school staff. Some of the accidents and illnesses they suffer may be part of the condition of childhood, but some may be caused or exacerbated by the physical and social conditions of school. Our survey aimed to consider factors associated with accidents, the division of labour for the care of children, and the resources available at school in terms of staff training and places designated for care.

Accidents

The incidence of accidents at school will be partly a reflection of the physical and social environment of the school. Some schools have very hazardous layouts and playspaces, some are overcrowded. The quantity and quality of supervision at playtime is relevant, as are the school's interventions to reduce potentially hazardous situations. And whilst overcrowding and lack of supervisory staff may not be within the control of the school, the quality of the supervision and identification and elimination of some potential hazards are more so.

One junior school identifies links between the physical environment and accident rates: 'The condition of the tarmac [in] the playground is such that accidents are becoming more regular.' However to alleviate the situation, proposals were underway to mark the playground with games 'which will cut down on games involving running around'. Another large junior school reported that the playground was extremely crowded:

> A separate infant school shares the playground at lunchtime — only four supervisors covering two buildings and two playgrounds at lunch, with 290 children — not sensible or right.

We asked for information regarding the most recent three accidents over the course of the current school term. We specified accidents where the child was out of class/work for half an hour or more — the criterion used in an ILEA survey cited by King and Ball (1989). Legislation on the recording and reporting of accidents at work does not automatically apply to schools; LEAs have their own systems and requirements and may ask schools to keep an accident book (Stock, 1994, Chapter 6). For this survey, we were therefore asking schools to report accidents of some severity. It is likely that schools would record accidents to children's heads, since these require monitoring, but some schools may have reported the most memorable accidents (perhaps the most serious) of that term rather than the most recent.

In all, 126 (20 per cent) of the 620 schools reported they had had no accidents so far that term (about three-quarters of the way through the autumn 1993 term), 17 per cent (103) reported only one, 8 per cent (52) two and 37 per cent (232) three. No information was supplied by 17 per cent (106) of schools. (We have treated these cases as missing in the analysis, although some may have been nil returns; thus the percentage of schools returning no accidents may be an underestimate.)

In total, we have information on 903 accidents. As suggested above, causative factors are complex but, as one might expect, schools with fewer children reported fewer accidents; 44 per cent of schools with under 100 children, but only 12 per cent of schools with over 200 children, reported no accidents. Age-range of the school is relevant — the junior/middle schools were more likely to report accidents (93 per cent) compared with all-age primary schools (79 per cent) and infant schools (78 per cent). Since older children engage in active, boisterous play in the playground, they are the most likely instigators and victims.

Most of the reported accidents — 73 per cent — occurred in the playground, 8 per cent in the classroom; 8 per cent while doing sport or PE; and 11 per cent happened at a variety of sites, the school hall, stairways, corridors or 'indoors'.

Most frequently the accidents involved injury to the head (61 per cent), while 18 per cent involved shoulders, arms or hands and fingers and a further 18 per cent related to legs, knees and feet. Only 3 per cent involved some other type of injury. Overall, almost half of all the accidents reported (48 per cent) were to heads and happened in the playground. Injuries to legs were more likely to take place in the playground or during sports or PE, whilst arms and hands/fingers were likely to suffer damage almost anywhere.

Most of the accidents (77 per cent) we classified as 'minor first aid', they had required little or no treatment; but 22 per cent were 'major first aid', and had involved more treatment within school. Only twelve of the accidents (1 per cent of the total reported) were rated as 'major medical', requiring out-patient care. The junior schools reported significantly more accidents and more major accidents, than did the all-age primary or infant schools.

Although head injuries were the most commonly recorded, 90 per cent of these were dealt with as minor first aid with only 9 per cent requiring more serious attention. Yet 54 per cent of injuries to the upper limb and 31 per cent of those to the lower limb required major first aid or medical intervention. There may be several explanations for this phenomenon: for example, the LEA may require schools to record head injuries, or staff may decide to do this since they perceive risk of concussion or delayed symptoms.

We asked, too, if parents were contacted at the time of the accidents. Overall, schools reported that they contacted parents in 76 per cent of these accident cases. In 22 per cent, contact was not attempted. In only 2 per cent did the school attempt unsuccessfully to reach parents. Where no contact was attempted, some schools commented that a note was sent home (a standard 'bump' letter was sometimes mentioned). We also found that although in 27 per cent of minor first aid cases parents were not contacted, virtually all were (except 5 per cent) in the major first aid category. With the twelve major medical accidents, parents were successfully contacted in all but one case. The fact that parents were uncontactable in only 2 per cent of the cases to some extent acts as a corrective to comments made on the questionnaires about parents being unobtainable when children are taken ill at school.

> [Difficulties with] contacting parents when pupils are taken ill, as only about 40 per cent of the parents have a telephone contact number. (Small town primary with 200 children)

Illness

The complex matter of the incidence of acute and chronic illness was not covered in our survey, but clearly caring for such children is an important part of what schools do. A report on the *Health Needs of School Age Children* (BPA, 1995, p. 43) asserts that 9.6 per cent of children under 15 years have an illness chronically reducing their functional capacity (such as asthma, diabetes, epilepsy); and, in addition, some school entrants have visual and hearing impairment (5 per cent and 5–10 per cent respectively). As well as these diagnosed conditions, children ask for recognition of and care for many illness episodes: stomach pains, headaches and sickness. Increasingly, too, children with other physical, emotional and mental disabilities are in mainstream schools. The care of all these children, as well as of well children falls on teaching and non-teaching staff — the lay health-care system of the school.

Schools' physical and staffing resources for this caring work are explored here, but we note first that a sizeable proportion of respondents (54 per cent of 191) who commented (under Section F of the questionnaire, see p. 240) on problems with caring for children's health identified difficulties with parents, whose poor health care impacted on the school.

> When children are ill and in our medical room, we cannot look after them all day. Some parents can't be contacted or get angry if required to come and collect their sick child. (Junior school with over 400 children)

> We have a problem of persuading parents to keep children at home when they have tummy upsets until they are fully recovered. Also same problem with sore throats and coughs. Many come straight from the doctor clutching antibiotics to take in school. (Large town infant school with 156 children)

Parental views tend to differ from these; the evidence suggests that they regard themselves as responsible for their children's health, and think they should be asked to come and take over if illness strikes at school (e.g., Ribbens, 1993; Mayall, 1994a, Chapter 5; see also Discussion pp. 216–19).

The management of asthma is becoming an increasingly important function of the school, given that rates are reportedly increasing (BPA, 1995, p. 2). Primary teachers are likely, according to some estimates, to have two or three asthmatic children in their class, and need information about management (Carruthers, Ebbutt and Barnes, 1994; Bannon, 1995):

> Asthma — Help! — So many inhalers having to be carried by school. (City infant school with 160 children)
>
> We do have to cope with an increasing number of asthmatic children. The welfare assistant is responsible for administering their inhalers daily. (Small town infant school with 128 children)

The division of labour and responsibility between the school and parents is an issue here, as one respondent noted:

> Difficult parents: an asthmatic child whose parent requested that all children suffering from asthma should be checked by flow meter.

Some schools had accepted that asthmatic children are here to stay. For instance, this rural infant school was taking positive steps to get to manage the situation:

> The head has recently attended a course on asthma and we are intending to have an asthma policy. The school nurse came to talk to staff about it. The school nurse is a great help when we have a problem and talks to the children regularly.

Guidelines, Sick Rooms and First-Aid Equipment

Both accident and illness at school require care: staff with time and skill to administer first aid and supervise the children, and a suitable place for the child to rest until recovered or until a parent takes over. Traditionally, primary schools have not had staff paid to do the caring; rather teaching and non-teaching staff have added care onto their other duties. The general caring function of the school is extended to cover care of ill children and of children with accidents.

The presence of guidelines for the management of these incidents may be one indication of what priority the school gives to addressing these situations. Overall, 58 per cent of schools had written guidelines for both illness and accident. A further 14 per cent had guidelines for accidents but not illness, and six schools (1 per cent) reported having guidelines for illness but not for accidents. However, 25 per cent reported that they had no guidelines for either eventuality. Schools reporting no accidents, and schools reporting three accidents, were just as likely to report having or not having guidelines. However the size of the school was important, for whereas only 57 per cent of schools with under 100 children had written guidelines for accidents, this rises to 80 per cent of schools with 300 or more children. This finding presumably reflects the point that larger organizations need to have more formally established guidelines, whereas smaller ones can operate on tacit, mutually negotiated and agreed ones.

In our view, schools should have suitable and specific accommodation for the care of children and for the work of the school health service. In practice, fewer than 20 per cent of schools had a sole-use first-aid room or one they shared only with the school health service. The commonest arrangement, reported by over half of schools, was for first-aid work and care of ill children to be carried out in a room shared with another, non-health related activity. The head's or secretary's office, the staff room, the supervisor's room, the library — all are pressed into service. A number of schools reported that the first-aid room was shared with the store room and/or with the photocopier. Finally, 12 per cent of schools reported that they had no room available for the school health service and 37 per cent that they had nowhere for children to rest when they were unwell.

As might be expected, older schools were less likely to report having rooms available, with more recent buildings being somewhat better provided (cf. NUT, 1963, Table 12). Thus 54 per cent of schools built before 1903, compared with 30 per cent of those built after that date, had no first-aid room, and proportions are roughly similar for the three later periods (1903–44, 1945–65, post-1965). Some more modern schools had been built with first-aid rooms originally, but, with rising numbers and more administrative functions, schools had diverted these rooms to other purposes: usually as an administrative office (this had happened at Town School).

The larger the number of children on the roll, the more likely was a room to be available: only 41 per cent of the smallest schools (under 100 children) had a first-aid room, compared to 81 per cent of schools with 300 or more children. As this small town school, built after 1966 and with over 200 children, describes:

> No facilities for the sick/ill child. Have use of our one room (staffroom/office) or Z-bed in the corridor.

This small rural primary reports:

> No room for the sick child. The ill child has to be monitored in classrooms until a responsible adult can arrive.

This infant school highlights as one of its particular strengths how it deals with sick children and its facilities.

> Good practice with medication e.g., for asthmatics etc. Good practice for first-aid. We have just improved our medical room facilities to include a shower unit and new facilities. (Small town infant school with 186 children)

Whilst it may be a matter for concern that most primary schools do not, on this evidence, have a room set aside solely to provide for caring for children when they are ill or have an accident, some schools may cope well through use of other spaces. Many more modern schools have some elements of open plan and may readily be able to designate a quiet area where a child can rest, in sight of adults, and/or in sight of their classmates. Children may prefer being with an adult; on the other hand, ill children may prefer a private space where they can rest away from the hurly-burly of school activities. We know from the case-studies that for school staff an important issue is supervision. Some schools prefer to keep children under the eye of staff in, often, the secretary's room, especially since they cannot spare staff to oversee them in a separate space.

We also enquired whether the first-aid equipment available was adequate in terms of both quantity and quality; most (93 per cent) were happy with the quantity of first-aid equipment and only 4 per cent unhappy (3 per cent did not reply); and similarly 87 per cent were happy with its quality, with 5 per cent unhappy (8 per cent did not reply). Several schools commented on the limitations imposed by the LEA on the official contents of the first-aid box. Some schools take measures to get round these restrictions by keeping additional unofficial items. This primary school with 200 children reports:

> County Hall instructions tell us not to treat minor injuries in school except with cold water. I refuse to comply and cover ourselves by getting permission from all the parents to use whatever we feel is appropriate e.g., Savlon, plasters, making sure to identify any allergies beforehand.

Staff Health-care Training or Qualifications

Though employers generally must ensure there are first-aiders (one for each fifty employees) children's low social status ensures that this is not required of schools (Stock, 1994, Chapter 14). However, many LEAs do seek to improve this situation, and offer training courses for school staff. We asked schools whether members of staff had any first-aid or medical training. On the whole, as Table 1.9 shows, training was more common among non-teaching than teaching staff. But in 13 per cent of schools no member of paid staff, whether teaching or non-teaching, had formal first-aid or medical training.

Table 1.9 Percentage of schools with staff having health-care training by number of children in school and by type of staff with training

	Number of children in school			*Teachers with training*	*Non-teaching staff with training*	*All schools*
	Under 100	100–199	200 or more			
Number of staff with training						
None	21	13	11	38	30	13
One*	39	29	21	37	39	27
Two	17	18	17	12	14	18
Three or more	23	40	51	13	17	42
N	107	171	289	591	592	598

* Includes schools which reported that they had trained staff but did not give numbers so presumed here to have one only.

Not surprisingly, the number of qualified staff varied with the size of the school. Thus over half the schools with 200 or more children, but under a quarter of the smallest schools, had three or more qualified members of staff. Nearly twice as many schools with fewer than 100 children had no-one on the staff with first-aid training compared to those with 200 or more (21 per cent versus 11 per cent). Since over half of rural schools fall into the small category it is not surprising that 16 per cent of small town or rural schools had no staff member with health-care training, compared with 8 per cent of inner-city or city schools. This is of particular concern since access to a hospital Accident and Emergency Department is likely to take longer for such schools.

Quality of Health-care Training

We asked for the type and duration of training, and used the answers to devise a scale of training quality:

- *short first aid*: under six sessions or under three full days' training;
- *long first aid*: six sessions or three full days' training or more;
- *medical*: any nursing, medical or para-medical training (in most cases NNEB training was cited).

Altogether, in 44 per cent of all schools at least one member of staff had attended a short first-aid course. In 31 per cent of schools at least one member of staff had long first-aid training. In 8 per cent of schools a member of staff had some type of 'medical' or nursing training. So, given that school health service staff are based elsewhere, lay health-care knowledge and the knowledge acquired on short courses (whether recently or in the more distant past) form the basis for care.

Financial constraints and pressure of work provide one explanation for low levels of training. Some schools mentioned specific inset training in first aid, but money for courses has to be found:

> In order to obtain a first-aid qualification without using supply cover, staff had to use their own time. In the case of the headteacher this included evenings in holiday periods. First-aid training needs to be funded fully. (Rural primary school with twenty-three children)

And as this junior school head pointed out:

> It needs to be made easier for staff to gain first-aid qualifications e.g., two three day course in school time as a refresher. Ten evenings in the winter after work is not attractive. (Small town junior with 241 children)

A further issue for school staff is the burden of responsibility:

> [We are] trying to address the first-aid issue. No funding available and a certain reluctance among staff who do not wish to be held responsible should they give first aid in good faith. Possibility that a person administering first aid could be held liable, is holding interested parties back. No funding for training personnel. (Small town infant school with ninety children)

However, some respondents were very positive and confident that they were doing well. This large town infant school with over 300 children noted:

> Well-qualified, non-teaching staff (especially as regards medical and first-aid matters). Constant vigilance. Good methodical procedures for coping with accidents.

And this city school with almost 300 children describes a mixed picture — poor physical conditions, but some trained staff available:

> Lack of place to put children, sick and awaiting collection. No sick room/medical room. Availability of nursery nurses to spend time with sick/distressed children. Adequate equipment and contact numbers always at hand. Two first-aiders.

Satisfaction with Arrangements

The picture reported here on guidelines, space and qualifications indicates low assignment of resources to the care of sick children. It is also a commonplace picture — part of the usual social scene at primary schools. Some may argue that schools do not need anything more elaborate than a lay health-care system, run mainly by women, as an add-on job to their paid work as teachers, classroom helpers, secretaries and supervisors. However, our data suggest that some respondents were concerned.

Whilst a large minority (46 per cent) of schools reported that they were satisfied with the arrangements in their school for treating sick children, 43 per cent reported that the arrangments were satisfactory to a certain extent and seventy schools (11 per cent) said that their arrangements were not satisfactory. Given, as noted earlier, that schools regard themselves as caring places, these percentages suggest considerable dissatisfaction (see Table 1.10).

Table 1.10 Percentage of schools reporting satisfaction with arrangements for ill children by guidelines, trained staff and first-aid room

	Satisfaction with arrangements for treating ill children			
	Yes	To some extent	No	N
Schools with written guidelines or policies				
For accident and illness	53	37	9	357
For accident only	45	37	17	86
For neither	32	54	14	163
Presence of staff with health-care training				
None	34	46	20	80
One or more trained staff	47	43	10	510
Availability of first-aid room				
Sole use of room	61	34	5	62
Shared with SHS*	62	36	2	45
Shared with others	48	41	11	275
No room	35	50	15	228

* school health service

Satisfaction was linked to better resources. Thus over half those schools (53 per cent) which had written guidelines for children becoming ill or having accidents reported that they were satisfied with their present arrangements. Among schools without guidelines, 32 per cent were satisfied. Similarly, where schools had staff with first-aid training more reported satisfaction: 47 per cent compared with 34 per cent of those with no qualified member of staff. Thus where schools had taken action, they were likely to be satisfied with the lay health-care system they offered.

Table 1.10 also shows that there was a clear relationship between satisfaction and having a first-aid room. It would seem that having a designated, readily available room (whether sole use or shared with the school health service) was regarded as important for good care.

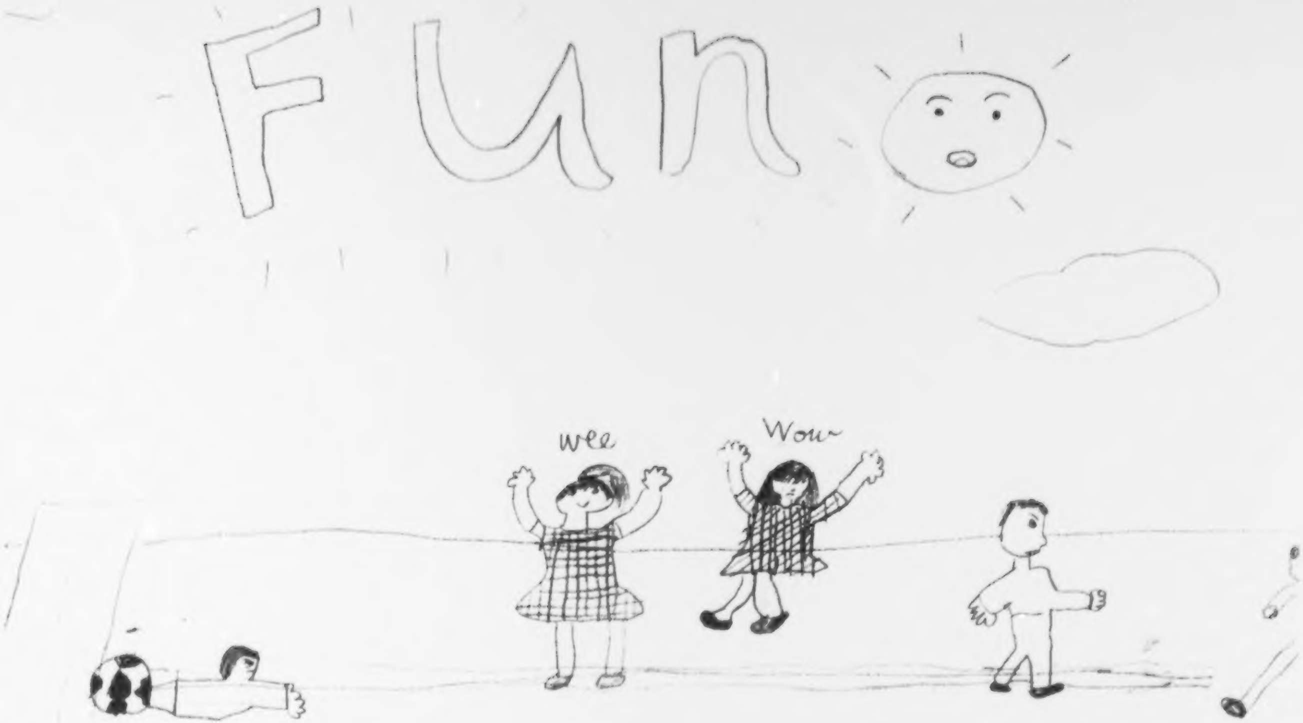

Figure 1.3 In the playground: 'FUN'

Comments

This section has considered factors relating to the status of children's health at school. Specifically we have been concerned not with health maintenance but with health restoration: cure and care for illness and accident. It seems that many agencies and many traditions contribute to the situation we have described. Planners of older schools made no provision for a sick room; the school health service is an inspection system not a curative service. Recent government policies have led to larger numbers of children in some schools and the conversion of sick rooms to other purposes, notably administration and financial management. Though our data do not allow us to study the relationships between overcrowded, unsafe playgrounds and accidents, we note that respondents to the survey, and in the case-studies, perceive links. Above all, long tradition assumes that teachers and other staff — the secretary, supervisors — will turn their hands to care. Caring is women's work. Finally, it is also assumed that mothers remain responsible for their children's health at school, and should take over the care. All these topics are considered in more detail in the case-studies.

5 Food at School

Children think that food is an important component of the school day — along with play and friendships it tends to feature largely in their conversations (Mayall, 1994a, Chapter 3). Studies also show that young children regard food as the principal factor leading to health, with exercise also identified increasingly by older children (e.g., Williams, Wetton and Moon, 1989). Both their happiness and their nutritional status will be affected by the quality and quantity of food available to them. In the survey, we enquired about school meals, packed lunches and snacks at school.

School Meals

Take up of meals is declining and packed lunches are a growing feature of the midday scene. The 1980 Education Act abolished the national fixed price of the school meal, abandoned minimum standards and removed the statutory duty on LEAs to provide school meals for all children. In response, the proportion of children taking school meals in England fell from 64 per cent in 1979 to 42 per cent in 1991 (National Forum for Coronary Heart Disease Prevention, 1993, p. 32). More recently, LEAs have been required to put the school meal provision out to tender (compulsory competitive tendering), and consequently some provision is through catering firms. As Coles and Turner (1995) document, though most LEAs require the provision of 'healthy foods' in

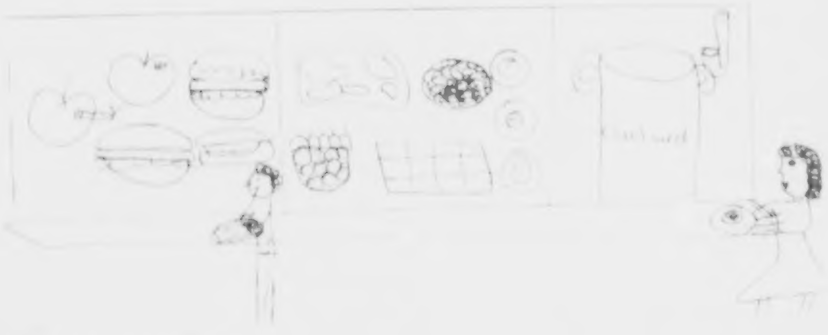

Figure 1.4 School dinner

the contract, healthy eating is not a priority with caterers; preoccupations now are with the efficient promotion of the service to sustain numbers and financial viability. The requirement to make a profit on the meal has led to the provision of popular foods, as well as 'healthy choices', and both children and staff (in our case-studies) note that much of the food provided and eaten is 'junk food'.

The provision of meals at school takes place within the context of budgetary considerations, the physical space available for cooking and eating, and children's and parents' choices between packed lunch and school dinners. And whilst staff may promote healthy eating in class, in practice there may be little connection between the recommended and the actual intake.

Almost all survey schools (92 per cent) offered school meals. They were provided in 64 per cent of schools by the LEA, in 23 per cent by a catering firm, and in 4 per cent by the school itself. In forty-nine schools (8 per cent) no meal was offered except to those eligible for free school meals; these schools were concentrated mainly in a few LEA areas, mostly in six county areas.

Asked to rate the quality and quantity of school meals, nearly half the schools (49 per cent) rated the quality of the dinner as very good or good, 34 per cent as average and 16 per cent as poor or very poor. Respondents tended to give similar ratings for quantity as for quality. Thus, 43 per cent of all schools rated their dinners as very good or good in both quality and quantity and 10 per cent rated both aspects as poor or very poor.

Our questions on what respondents thought were the strengths and weaknesses of their school elicited some comments on the quality of school meals. Comments ranged from 'Very good school dinner with great range of choice — especially with salads' and 'Well balanced (non-cafeteria) meals' to 'New school meal service very poor' and the pithy comment: 'brought in from elsewhere'.

Not surprisingly, those few schools (twenty-seven) that provided the dinner themselves tended to rate it more highly than schools where the LEA or a catering firm provided it. Thus most of the twenty-seven (twenty-one or 78 per cent) rated the dinner as good or very good, whereas only 48 per cent with LEA provision and 47 per cent of those with catering firm provision did so.

Most schools accommodated specific diets within the school meal: 88 per cent catered for vegetarian or vegan diets, 62 per cent for ethnic or religious choices and 78 per cent for certain health conditions. For each type of diet, the proportion of schools that provided it decreases as we move from inner-city to rural, from larger to smaller schools. This finding must relate to the mix of children in each type of area and to the likelihood that small schools (many of them rural) do not face a range of dietary preferences.

We were interested in whether schools and caterers discussed the menus for the school meals, as one means of assessing schools' interest in and influence on the food provided. Of the 563 schools which responded on this, 47 per cent reported that there were no arrangements to discuss menus. Just over half (51 per cent) reported some kind of liaison, including policy discussions (19 per cent), ad hoc discussion (27 per cent) and other types of liaison (5 per cent). The likelihood of discussions did not vary according to who provided the meal, the LEA, a catering firm or the school itself.

There is a relationship (possibly circular) between these discussions of menus and the rating of the quantity and quality of school dinners. Of those schools reporting policy discussions, 66 per cent praised the quality of the school dinners, compared to 44 per cent where there were no discussions.

We were particularly interested in children's own participation in discussion and in determining menus. Of 566 which replied on this, only sixty-three (11 per cent) reported involving children in this way, although several commented that children exert informal influence by what they choose and what they leave uneaten. There are no statistical differences by the age-range of the school although more older children took part than younger: child participation rates were 7 per cent (ten out of 127) for infant schools compared with 13 per cent (forty-four of 345) for all-age schools and 10 per cent (eight of seventy) for junior/middle schools. Size of school, at least for all-age primary schools is relevant, with children in smaller schools (that is, under 100 children) significantly less likely to be involved in determining menus than those in the larger schools. Schools which provided vegetarian meals or meals for those with health conditions were also more likely to report involving the children in menu planning.

In schools where no lunch is provided, and where children bring their own food, children entitled to a free school meal are generally given a packed lunch, provided through the LEA (as in one of our case-study schools: Village). None of the forty-nine survey schools (8 per cent of all) made any specific comments about this situation, although several schools commented positively in other parts of the questionnaire on the conversion of redundant kitchens to provide additional space for school activities. This city primary school anticipates it will lose its kitchen soon and has already allocated the space to two disparate uses:

> Kitchen closing soon due to LEA cuts — [it's] possible it may be, in distant future, used for first-aid/medical room or library.

Although only 8 per cent of survey schools were not serving school meals, this may be an increasing trend. The loss of the school dinner raises two main concerns in terms of health maintenance. Firstly, there is a need to provide suitable storage space for the packed lunches during the morning. A classroom may accommodate a few lunchboxes but keeping thirty packed lunches cool and away from marauding ants is more difficult (as we heard at Village). Secondly, where children bring packed lunches, inequalities in the nutrition provided are likely to widen; and school staff may not regard intervention as morally desirable.

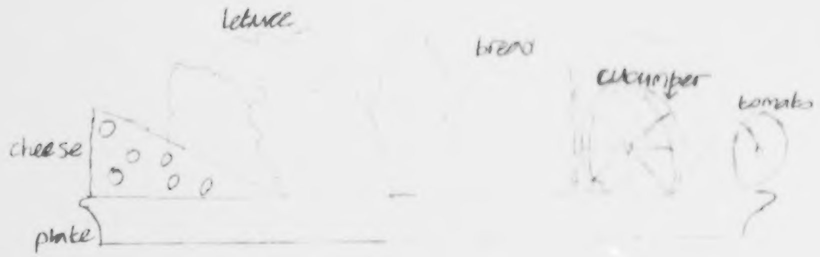

Figure 1.5: School dinner: a healthy meal

Other Food Available in School

Among the vast number of tasks schools carry out, selling or providing food continues to feature and 45 per cent of schools reported that they sold or provided some food in addition to the school dinner. Milk was the most commonly sold food (16 per cent of all schools) and almost a quarter of infant schools (24 per cent) provided or sold milk — significantly more than either primary (15 per cent) or junior schools (6 per cent). In fact, 19 per cent of infant schools compared with 8 per cent of the primary schools and 1 per cent of the junior schools reported that the only item they sold was milk. However 17 per cent of junior schools, 11 per cent of the all-age primary but only 5 per cent of the infant schools reported selling some other sort of drink.

Other foods were less commonly sold or provided. Crisps were listed by 29 per cent of junior schools, 14 per cent of the all-age primary schools and 7 per cent of infant schools. Fruit was sold by only 8 per cent of schools. A variety of other snacks were mentioned, with some comments emphasizing them as healthy snacks. Fifteen schools specifically mentioned having a tuck-shop selling sweets and chocolate.

Some schools saw the provision of these extra snacks as a strength and a positive addition to the school, whilst others thought the course they were pursuing was a weakness. So whilst some commented that selling snacks was justified in terms of satisfying hungry children at break, and as a means of raising money for the school, others noted the value of using staff time for other activities, or the nutritional disadvantages of selling popular snacks.

> Children on free lunches are often hungry at break (10.30 a.m). We have to make our own arrangements for provision of a snack — they can't perform well on empty stomach. (South-west primary school)

> [Under weaknesses of school, F2] Encouraging children to eat sweets as a fund-raiser. (Rural primary with sixty-one pupils)

> Tuck-shop is traditional — this will be a long battle. Initially limit tuck-shop to fruit, crisps, no sweets. Aim to encourage fruit from home and eventually no tuck-shop. (Small rural primary school)
>
> We could stop selling crisps in the tuck-shop but it is a good fundraiser. (Large town junior school)

Packed Lunches

Only five survey schools reported that they did not permit children to bring packed lunches and only one school restricted packed lunches to certain age-groups. One of these schools, a small infant school with thirty-four pupils, made comments which may have been relevant to its decision to exclude packed lunches:

> Actively discourage the consumption of soft drinks, sweets, chocolate, etc. on school premises. No tuck-shop. Reasons for above policy are explained to children.

Several other schools, whilst not banning packed lunch, mentioned the good take-up of school meals. For instance, this rural junior school adopted a policy of

> encouraging children to try such things as healthy foods in school meals and not resort to packed lunch, crisps, biscuit approach.

In the questionnaire section (F3, see p. 240) where we asked whether the school faced any specific problems in maintaining children's health, packed lunches generated many comments about parental ignorance about nutrition, and the poor diets provided at home; also about the conflict for teachers between respecting parental and child choice and preference, and valuing health promotion messages.

> Children with poor home diets. Children with poor packed lunches. (Inner-city primary with 290 children)
>
> Yes, appalling quality and quantity of packed lunches provided by some parents e.g., one chocolate bar. (Town primary with 200 children)
>
> Generally poor quality of packed lunches in spite of past campaigns for healthy living. (Large town junior with 186 children)

The following two sets of comments are from small rural primary schools where no meals were provided except for those entitled to free meals, so that all the children were having packed lunch.

> Packed lunches from home are often lacking in nutrition e.g., too much chocolate, white bread, not enough fruit.
>
> Packed lunches — I cannot/will not dictate what parents provide.

However, many schools did take a pro-active approach to food consumed at school, through the prohibition as well as provision of food. In all 51 per cent restricted the contents of packed lunches and 80 per cent banned some snack item; 45 per cent did both. Notably, greater efforts went into dietary influence on the younger than for the older children. Thus, 53 per cent of infant schools, compared with 44 per cent of junior/middle schools and 43 per cent of all-age schools banned items as snacks and in packed lunches. And only 7 per cent of infant schools reportedly banned nothing, compared to 17 per cent of all-age schools, and 26 per cent of junior schools. It seems from respondents' emphasis on sweets and soft drinks that schools identified sweet foods as the main problem, though nutritionists argue that children consume too many fatty foods (Cole and Turner, 1992, p. 14).

It is worth noting here, that very few schools reported pursuing specific policies to promote good nutrition. Only 10 per cent did so, with 85 per cent reporting general policies. There was no relationship between the banning of foods and either specific or general nutritional policies. So the data suggest that, whilst respondents in many schools tried to control nutrition to some extent, they did not regard these controls as constituting a specific policy.

Food at school is an aspect of the school day which highlights divisions of responsibility between parents, school staff, caterers and the national policies that affect all these groups. The children's diets are constructed within these people's interests, as well as by their own preferences. The data reported on here indicate considerable disquiet among respondents about the quality of children's food at school. As regards the school meal, there is division of responsibility in most cases, between the school and caterers, and the latter may have little contact with the staff. In very few cases did children themselves have any say in the menus for school meals. Children or their parents do make decisions about what is eaten in school, by opting for packed lunches or by bringing snacks to school. For parents, the economics of meals, snacks and packed lunches are important here — a point we pursue in the case-studies. Schools may try to influence children's diets but, again, economic and moral factors intervene.

Health Maintenance Index

To gain an overall picture of how well the survey schools dealt with health maintenance issues we constructed an index comprising elements relating to food, exercise and first aid. This covered some aspects which were directly within the control of the school, such as banning certain foods and having policies for accident and illness; and others which were somewhat outside its control — having a first-aid room, the quality of the school dinner provided. (See Appendix 3 for detail.)

This index is concerned with the package that schools deliver, based on what is and is not under their power. None of the survey schools scored the maximum on this index, and the main factors that denied otherwise successful schools the maximum were the lack of a first-aid room and average rating of school dinners. Good scores on this index are significantly related to good scores on the index of the physical environment especially the building (see Table A3.2, p. 246). Those schools with a post-1965 building achieved the highest scores on the rating and those built pre-1903 the lowest. Only 4 per cent of pre-1875 schools and 14 per cent of 1875–1903 schools have a separate first-aid room or one shared with school health service (SHS) compared with 23 per cent of those post-1944. In addition, the ratings of curricular exercise and opportunities for play were less good for the older schools.

This health maintenance index is, of course, a personal choice on our part, composed of elements we studied and thought important. But, as generally in the study, it aims to draw attention to the many factors that go to make up a healthy environment for school children; to point to the many interventions and innovations schools can and do implement; and to emphasize the uphill battle some have, faced with unsuitable buildings and financial constraints. The findings on this index suggest the powerlessness of even the most interventionist schools to provide a health-promoting school life for the children; where the physical environment is poor, and where market forces determine the quality of food provided (see also Table A3.3, p. 246).

6 Health Education and Health Promotion

In this study we have used the phrase 'health education' to refer to the teaching of information about determinants of health, whether to individuals or to groups. We have used the phrase 'health promotion' to refer to a wider set of activities, including health education, but addressing the determinants of health: the physical, social and political environment. In this we follow the work of the World Health Organisation (WHO, 1984), which argues that health promotion involves improving access to health, developing an environment conducive to health, strengthening social networks, promoting positive health behaviour and increasing knowledge. We also agree with WHO's Director General:

> Health is indivisible — the domain of personal health over which the individual has direct control is very small when compared to the influence of culture, economy and environment. (quoted in Parish, 1995, p. 25)

Though a school's direct contribution (positive or negative) to children's health may be through the quality of the physical environment and through policies and practices on exercise and food, schools are also encouraged to develop health education policies and whole school health promotion policies. Our aim in the survey was to provide a broad picture of the type and range of school activity as to policies in both health education in the curriculum and whole school health promotion.

At the time of the survey (autumn 1993) and at the time of writing (autumn 1995), the National Curriculum Council (1990b) guidance was and is the most recent. This proposes that health education is, though not a core subject, an essential one, which may be pursued through cross-curricular methods; and that health should be promoted through 'wider aspects of school life' (NCC, 1990b, Preface). Drawing up and implementing a health education policy will be facilitated through the appointment of a coordinator, but as an HEA survey (Health Education Authority, 1993, Preface) notes, grants for such posts were ended in April 1993. How schools deal with this issue since then will depend on how they deploy their budgets, under the Local Management of Schools system.

Health Education Policy and LEA Policy

Overall, 62 per cent of survey schools reported that they had an agreed policy on health education. This compares with a 1992 survey where 49 per cent of schools had a written policy mostly completed (HEA, 1993, Table 2). The terms 'agreed' and 'written' may account for difference, but the passage of time may too. Of the 62 per cent, almost all (90 per cent) said this policy built on or used the LEA policy. In addition, 38 per cent of schools reported that they had a whole school health policy. However, though 35 per cent of all schools had both, 33 per cent had neither. Three-fifths (61 per cent) of schools reported they used guidelines from the Department for Education or the National Curriculum Council to help them draw up their policy.

This large junior school with 320 children explained its policy:

> We have developed a policy with our feeder infant school so that health education has continuity from 4–11 years. Health Education has a high profile in our school.

However, some reported that they were still in the process of developing their policies, completion being nearer for some than others:

> We need to formalize our policy on curriculum delivery in health education. (Inner-city infant school with 172 children)
>
> We are still in the process of developing whole school policy on health education with systematic involvement of SHS. (Large town primary school with 210 children)
>
> One day we shall put together a special health education policy. (Rural primary school with 260 children)
>
> Staff are aware of the need for health education and had a day's Inset which they found useful. Other curriculum areas are dominating at present but a policy will eventually be drawn up. (Town infant school with 128 children)

Schools with older children were more pro-active generally in health education than infant schools. Thus 76 per cent of junior schools, 64 per cent of all-age primaries and 55 per cent of infant schools had agreed policies. Similarly, whole school policies were more frequently reported by junior schools and primary schools than by infant schools.

A total of 63 per cent (392) of schools had a designated coordinator for health education: an increase over the HEA 1992 survey — 53 per cent (HEA, 1993, Table 7). This was usually either the headteacher or a specific class teacher, and more rarely the deputy head or a group of teachers. Schools with designated coordinators tended to have policies: they were twice as likely to have health education policies (agreed school policy, or whole school policy) compared to those without. Who takes on the role of coordinator relates to the size of the school. Of schools with under 100 children, whilst 36 per cent had no coordinator, in 41 per cent the headteacher was responsible. In the largest schools (300+ children), 31 per cent had no coordinator, the head was responsible in 10 per cent, but it was mainly class teachers, or senior teachers who acted as coordinators (59 per cent).

Most schools reported including health education in the curriculum in more than one way. Opportunistic and cross-curricular approaches were common, with half the schools teaching it through science. A minority (22 per cent) taught specific health education topics. Overall, 37 per cent of schools reported using only one method. Those including health education via science topics or health education topics were more likely to be using other methods as well. Again, 'as the opportunity arises' was cited as the only method by only 4 per cent of those using that method — generally, it was used in addition to other methods.

There were no relationships between the ways in which health education was included in the school, and whether there was a school policy, a whole school policy or a designated coordinator for health education. The fact that 38 per cent of schools had a whole school health education policy is reflected in the finding that many schools used opportunistic methods, or a range of methods to implement health education.

Table 1.11 Percentage of schools using specific method for including health education in the curriculum by age-range of school, and denomination of school

	Method of teaching health education				
	Cross curricular	Science topics	Health education topics	Opportunistically	N
Used as sole method	26	6	2	4	620
Used with other method	56	45	21	39	620
Age-range of school					
Infant	92	43	14	44	154
Primary	82	54	23	45	373
Junior	67	57	38	33	84
Denomination					
Non-denominational	85	50	25	42	402
Church of England	82	49	22	47	146
Roman Catholic	67	60	9	41	58

Generally, infant schools covered health education through cross-curricular topics, and junior children were taught through science and/or health education topics. This finding complements the general point that many younger children are still taught through an integrated day, and older ones increasingly in sessions devoted to specific 'subjects'.

Health education methods varied by the denomination of the school. The

Roman Catholic schools appeared least often to adopt health education topics specifically or to use cross-curricular methods. They were significantly more likely than the other denominations to approach health education through science topics.

We also asked how health education was included in the curriculum, in terms of whether the school used a spiral curriculum and whether it used block projects for specific age-groups. In 80 per cent of schools, health education reportedly ran across school years and 48 per cent used block projects for specific years. Over a third of schools (36 per cent) used both. Block projects were successively commoner through to the oldest children, used in 18 per cent of Reception classes and 44 per cent of Year 6 classes.

A range of perspectives on the importance of health education and the problems of fitting it in, are exemplified in the following comments. Some highlighted the policy and practice as a strength of the school: 'A very close policy built into a spiral curriculum.'

> A caring, dedicated staff aware of health needs of children and able to create teaching situations to reinforce healthy living practices as they arise in curricular and extra-curricular activities. (Rural junior school)

The problems of fitting in health education surfaced:

> Careful topic planning for health education, including road safety. Health related fitness planned for Year 4 children. Ensuring that all topics are covered in the time we have is always a problem. A general comment with regard to the curriculum, as I am sure you are aware: it is overloaded at this time and we are desperately keeping many balls in the air. (Rural infant school with 100 children)

Some schools were clear they could not afford to spend much time on health education:

> The school PSE [Personal and Social Education] programme which is included in our planning (by every teacher) alongside National Curriculum subjects. Healthcare is not a National Curriculum subject, therefore we cannot afford to devote too much time to it. League tables SATS results will not reflect what is done — however good it is isn't. (City junior school 360 children)

However, as in some of our case-study schools, some but not all staff had been enthused by ideas brought into the school:

> An American exchange has helped staff see new possibilities for Personal Education — Utah programme. The enormous pressures of

> the National Curriculum particularly the volume of content and records etc. Have reorganised PHE [Personal Health Education] — against the wishes of teachers. (Inner-city junior school with 290 children)

Despite the plethora of health education material available for use with school children, over half of those who replied on this (58 per cent) said they did not use any specific packages. This is consistent with the inclusion of health education in the curriculum by cross-curricular methods (and with constraints on time to draw up these policies). Although 38 per cent said they used packages, only a few specified which; 7 per cent mentioned *My Body*, and 6 per cent *Health for Life*. Again, schools with older children were more likely to use packages (sometimes on block projects); 54 per cent of junior schools compared to 44 per cent of primary schools and 29 per cent of infant schools.

Promotion of Healthy Behaviour

Schools were asked if they pursued general or specific policies to promote healthy behaviour in the areas of nutrition, exercise, safety, personal relationships, risky behaviours, personal health and dental care. The vast majority of schools reported policies, mainly general ones, under each category, except risky activities (a rather vague category). Our aim here was to find out what were school priorities, through a focus on the specific policies.

Table 1.12 Percentage of all schools with specific or general policies to promote healthy behaviour

	Specific policy	*General policy*
Nutrition	10	85
Exercise	21	76
Safety	28	69
Personal relationships	22	70
Risky activities	11	65
Personal health	15	80
Dental care	13	83

In total, 57 per cent of schools did not report aiming to promote healthy behaviour by a specific policy in any of the topics listed; 12 per cent promoted one topic specifically, a further 11 per cent two topics, 7 per cent three topics and 14 per cent had specific policies to promote four or more topics.

Nutrition and dental care were overwhelmingly catered for 'in general'. We have noted earlier under 'Food at School' the division of responsibility for food, with caterers and parents making many crucial decisions on meals and packed lunches respectively. Though schools did provide, sell and prohibit foods, it seemed many did not regard this as a specific policy, since schools reporting specific policies on nutrition were not more likely to sell healthy foods or prohibit unhealthy foods. However, they were significantly less likely to be selling crisps than other schools. As regards dental care, the division of responsibility is likely to be clearly drawn, with schools regarding dental care as a parental and child, rather than a school responsibility; and as a once-a-year responsibility of the school dentist.

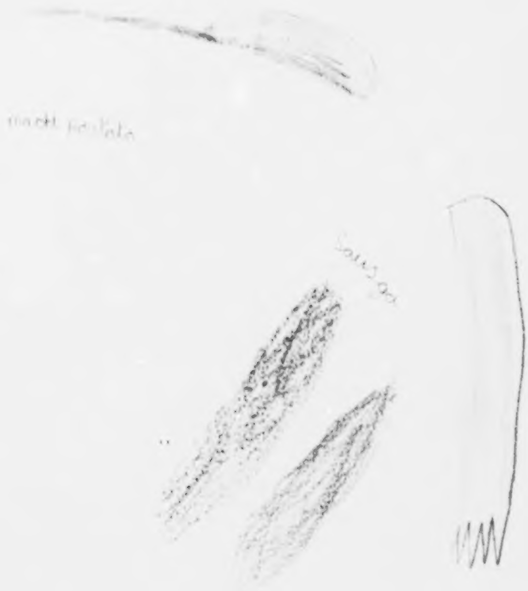

Figure 1.6 School dinner: mashed potato and sausage

Schools noted safety, exercise and personal relationships as the main areas they focused on through specific policies. Safety tends to feature early on in the formal and informal curriculum, as a suitable topic to cover with younger children; it is also top of the list (along with hygiene) in parental concerns about child welfare at school and outside (as case-study data show). As to exercise, those with a specific policy rated their play opportunities slightly better than other schools (62 per cent rated very good or good compared to 56 per cent). We cannot judge in which direction the cause — if there is one — runs. Similarly 80 per cent of those with a specific exercise policy rated their curricular exercise as good or very good compared with 70 per cent of the rest. Policies on personal relationships and citizenship are increasingly being developed within PSE and whole school behaviour policies, as part of school responsibility under Section 1 of the Education Reform Act 1988 (cf. NCC, 1990a).

Table 1.13 Percentage of schools promoting specific healthy behaviour topics, according to school health education policy and designated staff

Schools with	Number of topics promoted specifically			
	0	1–2	3+	N
Agreed HE* policy	53	24	23	385
No agreed HE policy	64	20	16	225
Wh sch HE policy**	52	23	24	233
No wh sch HE policy	62	21	18	362
Designated coordinator	54	21	25	392
No coordinator	62	25	13	223

* HE = health education
** wh sch HE policy = whole school health education policy

Table 1.13 shows links between health education activities and specific policies to promote healthy behaviours. Where schools had health education policies, or a designated health education coordinator, they were more likely to say they took specific policy steps to promote healthy behaviours. Many of the schools engaged in specific health promotion were those who dealt with health education via health education topics. Thus 29 per cent of schools adopting this method, but only 18 per cent of those using other methods, covered three or more of these topics specifically.

We looked to see if catchment area and age-range were related to the incidence of specific policies. Though 31 per cent of inner-city schools dealt with personal relationships specifically compared with only 18 per cent of rural schools, risky behaviours and safety were covered to a similar extent in all locations. The age-range of the school was not related to specific healthy behaviour promotion in nutrition, personal health and relationships and dental care but older children were more likely to have sessions about risky behaviours — in 18 per cent of junior schools but only 12 per cent of infant schools. Personal relationships were covered in 29 per cent of junior schools and 23 per cent of primary schools but in only 19 per cent of infant schools.

> Safety is a priority. We try to encourage awareness in diet, exercise and dental care. (Rural primary with thirty-one children)
>
> Regular health education input through PSE. Extra-curricular activities promoting physical exercise. Well balanced (non-cafeteria) meals. (Town junior school with 293 children)
>
> [Strengths of the school:] Sex education. Health and safety policies. Snacking policies. (Inner-city primary school with 380 children)
>
> We have received antagonism from parents regarding our anti-smoking initiatives. (City junior school with 125 children)

For some schools, health education was, at least wishfully, targeted at parents. The division of responsibility was an issue here, as in respect of the care of ill children.

> Nutritional policy and advice to parents. (Small town primary school)
>
> Dental care — several children in the junior class obviously don't clean their teeth regularly — this is harder to correct with older children. (Small rural primary school)

Outside Speakers on Health Education Issues

Health education is sited uneasily within current advice on the National Curriculum as a cross-curricular but important set of topics. It is a set of topics on which primary school staff are unlikely to have any specialized information or teaching skills. We enquired whether schools brought in outside experts to discuss any health education issues. Respondents indicated that school nurses featured most commonly, having been involved in 79 per cent of schools. This may have been partly in classwork, and partly as health advisers to individual children or groups of children. School nurses are familiar figures in some schools where there is continuity of staffing and reasonable work-loads (see Section 7, pp. 59–62). This town junior school (with 128 children) sums up a positive situation:

> The quality of support for health education in many schools will depend upon the relationship between teachers and the school nurse, who is always a first point of contact. We are lucky and have a good partnership.

This larger junior school in a different area is less fortunate:

> We are unhappy that the school nurse cannot help in the classroom. She could help in 'keeping ourselves clean', 'keeping ourselves safe', good diet, exercise, sex education and menstruation. Health authority only allows school nurse to discuss with teacher and give support. Not allowed to talk to children.

Other health professionals were reported to carry out health education in 35 per cent of schools. Few schools were visited by health visitors (18 per cent), and nurse tutors (4 per cent). The police maintained a high profile (48 per cent) but few schools had enlisted parents (13 per cent) as visiting speakers on health issues. A variety of other outsiders were mentioned and primarily these speakers covered aspects of safety: fire safety, road safety, water safety. Some speakers were presumably invited to talk about local conditions: the railway police, local building site managers and, in one case, the coastguard.

This city infant school, with over 250 pupils, was unusual in pursuing health education topics with Years 1 and 2 and noted: 'Use of school nurse/local constable/fire service with children and parents.' But on the whole fewer infant schools recruited outside speakers than did those with junior departments, that is, all-age, junior and middle schools. This point fits with the emphasis on specific health education topics with older children, noted earlier.

Health Education — An Overall Assessment

To get a measure of what schools were doing about health education, we constructed an index with a maximum score of five points. This took account of whether the schools had a health education policy and a whole school health policy, whether a member of staff was designated as responsible for health education and whether the school had specific policies to promote healthy behaviours. (See Appendix 3 for details.) This was an area in which the schools had complete responsibility, within the limits set down by the National Curriculum. Of our survey schools, 14 per cent of the schools scored zero whilst 20 per cent scored 4 or 5.

As we have already noted, the age-range of the school was particularly important: health education was more structured for older children. So, infant schools had the lowest mean scores on the index, with primary schools next, and junior schools scoring highest (Table A3.4, p. 247). There were no differences by area-type or by school size. However, the method of teaching health education was important: those who approached health education through health education or science topics scored significantly higher than those pursuing other methods, either cross-curricular or opportunistic methods.

Comments

Health education in schools is in a difficult position. Schools are encouraged to 'do' it, but space for it is difficult.

> Health education is an essential part of every pupil's curriculum . . . [It is a] cross-curricular theme . . . It is not an additional subject. Many elements of health education can be taught through the subjects of the National Curriculum and other time-tabled provision, in addition to being promoted through the wider aspects of school life. (NCC, 1990b)

In these words, the National Curriculum Council (NCC) presents schools with difficult decisions: how to fit health education into and across a busy school curriculum, and whether and how to adopt whole school policies. The document also raises another important issue: how can the school interlock health education in the curriculum with the promotion in school of healthy behaviours more generally, that is, what contribution can the school make to enabling children to live healthily?

We have already noted how schools have only moderate power to influence nutrition and exercise at school, and may face insuperable problems in the buildings and playspace, exacerbated by overcrowding. These dilemmas and decisions are considered in more detail in the case-studies. Some of our survey respondents illuminated key issues in health education. This city infant school with 300 children gave low priority to health education at school, and agreed with research findings that children learn health-care at home (e.g., Mayall, 1994a):

> There is little energy or enthusiasm in school for promoting health education in addition to the vast number of recent requirements. Much support and initiative is needed from outside agencies. On the whole, our children are well taught about health by their parents.

This city junior school with 360 children was pessimistic about school effects compared to other socio-economic influences:

> The power of advertising and popular culture has more influence than our teaching.

But the head of this town primary school (220 children) was enthusiastic about the value of its health-promoting work:

> Healthy Eating programme. Quality role models and high expectations of positive attitudes. Insistence on good habits to promote good health e.g., sleep, nutrition, personal care. The Healthy Eating programme will extend each year. Policies need reviewing soon. My personal feelings are that health issues in primary schools are of great importance. This is where the child is greatly influenced and it often has to compensate for strong media influence and poor parenting skills.

7 School Health Service (SHS)

Overseeing the health of school-age children is a requirement on the health services. Health authorities must make provision for the overseeing of school-age children's health, and the British Paediatric Association (BPA) points to school entry and ages 7–8 (Year 3) as key points; they recommend the nurse carries out a health interview at age five with a parent present, and measurement of weight, height, vision and hearing, with referral to a doctor for any problems, and further sight-testing and referral at age 7–8 (BPA, 1995, p. 51). However, how local health authorities organize and deliver the service is up to them. At the time of writing we know that a few districts have abandoned the traditional SHS, and work with school-aged children through GPs (general practitioners) and community health services. In some areas, children are inspected before they start primary school. As far as we know, there is no national information on current SHS input into schools.

We collected baseline data on numbers of visits by SHS staff, turnover of staff, and the types of service provided, including input into health education. We also asked schools about liaison arrangements between the SHS and school and parents, about satisfaction with the service and for suggestions for improvement.

As previously noted, the SHS operates in most schools in less than ideal physical conditions. Only 30 per cent of the schools reported a room provided solely for the SHS, although a further 7 per cent shared with a first-aid or casualty room. The commonest arrangement, in 320 schools (45 per cent), was for the SHS to use a room with another designated use — the library or the office — but 16 per cent of schools reported no room, and 3 per cent of schools reported other arrangements or the information was missing.

SHS Staff Visits

Table 1.14 shows the considerable variation in the numbers of reported visits by SHS staff. In 19 per cent of schools the doctor visited only once a year and in a further 37 per cent only two or three times each year. Most dentists visited once a year (71 per cent), with only 13 per cent visiting more often. For the school nurse, lynchpin of the service, there was a particularly marked variation; nearly a quarter of schools (24 per cent) were visited once a term or less, whereas 41 per cent were visited more than three times a term, including 17 per cent with weekly visits. Four schools reported no visit from the nurse.

Table 1.14 Frequency of visits by nurses, doctors and dentists (%)

	Nurse	Doctor	Dentist
Number of visits			
None	<1	2	4
Once a year	4	19	71
2–3 times a year	20	37	11
4–9 times a year	26	20	2
10 times a year or more (but less often than weekly)	24	6	0
weekly	17	2	0
frequency not recorded	10	14	13
N	620	620	620

fourteen schools reported no visits from the doctor and twenty-three schools no visit from the dentist. Comments suggest that frequency of visits may depend partly on policy, partly on staffing levels. This rural infant school with over 200 pupils compares itself unfavourably with neighbouring schools.

> In an area adjacent to ours the schools receive weekly visits, have close cooperation. We have a part-time nurse who has too heavy a load and in 18 months we have had absolutely no contribution from the SHS. Parents have asked about a variety of matters which have been referred immediately but it seems the local area is very short staffed.

Another city junior school with over 300 pupils and reporting no visits from the doctor noted:

> The lack of a school doctor (preferably experienced) is most unsatisfactory.

A small town junior school explained that the school health service's:

> involvement in schools has diminished because of cutbacks in the health service. However, quality of service is the same as before only quantity is different. Improvement would be [an] increase in number of visits.

And cutbacks in the service led to anger at the impact on teachers' responsibilities.

> After initial screening of reception class we are left to diagnose symptoms. Cuts in health service are the cause. I am not a qualified nurse or doctor and should not be left to diagnose problems. More health checks for older ones needed. Teachers are left to diagnose symptoms. (Town primary with 140 pupils)

As well as local health authority policies and cutbacks, it seems likely that numbers on the school roll will affect frequency of visits and that inner-city health authority areas may respond with higher input to perceived high rates of child health problems. Indeed, inner-city schools received significantly more visits from the nurse than other schools. And nurses visited larger schools more often, so that, whilst 48 per cent of schools with under 100 children reported up to three nurse visits per year, only 14 per cent of schools with 200 or more children had this few visits. Only 13 per cent of the smaller schools reported more than three visits per term from the nurse compared with 58 per cent of those with 200 plus pupils. Similarly with doctors' visits: 36 per cent of small schools, but 16 per cent of the largest schools reported only one visit per year.

Since small schools are concentrated in rural areas and large ones in cities and towns, comparisons by catchment area are compatible with these findings. Among city schools only 13 per cent, and among inner-city schools only 18 per cent, reported one visit from the doctor, whereas 33 per cent of rural schools did so.

The age-range of the school is also a factor related to differences. Infant schools reported more visits from the doctor than did the other schools; 40 per cent reported two or more visits from the doctor each term compared with only 26 per cent of primary schools and 15 per cent of the junior/middle schools. This concentration on the lower age-groups probably reflects the established practice of screening school entrants.

To look at variation more closely, we used the ratios of nurse and doctor visits per child. Certainly inner-city schools had significantly more favourable ratios of nurse–child visits than schools in other areas; schools in small towns reported the worst. Infant schools reported better ratios of nurse–child visits, compared to primary and junior schools. But when we took the location of school into account, there were no significant differences: inner-city infant schools did not get significantly more visits than infant schools in rural or small town locations. This latter finding also applies to doctors' visits. However, when comparisons were made between areas for all schools, then rural schools as a whole did better for doctors' visits per pupil than did inner-city schools.

> School nurse has too many schools to deal with and as a result is not able to devote enough time to any one school. (Rural primary school with over 350 children)

Another primary with 200 pupils and recording five nurse visits a term would like to see more visits, making her more involved with the school:

> A permanent attachment to the school on a half-day-a-week basis of school nurse. She should be seen as a real member of the school staffing team, not an 'add on'.

However, many schools were positive about the time the nurse spent with them. This infant school with 188 children and ten nurse visits a term says:

> School nurse is regular visitor — excellent.

And an inner-city primary with over 250 children detailed the excellence of their nurse:

> We would very much like to keep our wonderful school nurse who is a source of expertise, advice and information.

SHS Staff Turnover

We asked about SHS staff turnover over the past three years, since staff continuity is valued by schools and could be a source of security for children. Whilst 43 per cent of schools reported that they had had the same doctor for the past three years and 55 per cent reported having kept the same nurse; at the other end of the scale, 15 per cent of schools reported an average of a new doctor each year and 7 per cent an annual change of nurse. Reported turnover was significantly higher in inner-city schools compared to rural schools; thus 10 per cent of inner-city schools, but only 4 per cent of rural schools, reported three or more nurses. Differences for doctors were more marked — 36 per cent of inner-city schools, but only 9 per cent of rural schools reported three or more doctors over the three years. No doubt, costs of housing and career patterns among trainee doctors are relevant to high inner-city turnover.

This town primary with over 400 children reported three nurses in as many years and added:

> We desperately need a local community school nurse. Someone who is able to get to know the community the families and has links with all agencies including the local doctors.

Another city primary with as many pupils and a similar rate of turnover noted:

> Long gaps occur when SHS personnel have maternity leave or move to different jobs. We need someone to call on who knows the school and the children please.

Another reporting two nurses and four doctors in the past three years thought that the service would be improved with: 'Continuity of staff. Consistent practice and policy'.

Medical Services Offered

Table 1.15 shows the percentage of classes/year groups reported to have received services from the SHS; this table includes both services which may be universalistic and those available on request. That is, in some cases the whole class probably filed through, in others a few children were seen.

Table 1.15 Services offered by SHS, by year group (%)

Type of service	School Year						
	Reception	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Whole class surveillance	42	16	13	14	14	13	22
Consultation	61	64	64	61	60	61	63
Health interview	38	21	16	19	18	18	29
Hearing test	73	50	45	45	41	39	47
Sight test	76	47	45	48	43	42	56
Dental checks	73	70	64	65	64	63	65
N	524	532	532	502	486	456	454

As Table 1.15 shows, the SHS concentrates some of its major efforts on school entrants and on the top class. Whether the service routinely screens every child or offers a consultation on request (by health staff, school or parent), as is now becoming common, it seems that high proportions of children were seen during their time in the Reception class. Hearing, sight and dental checks were also concentrated in that year. A relatively new idea is the health interview or health assessment, where general health issues can be raised by children, parents and health staff (Health Visitors' Association, 1992) and Table 1.15 shows more of these in the reception class and again in Year 6 than in other years. The consultation on request seems to be in favour, with three-fifths of each year group having children who were seen.

We looked to see how many infant and primary schools were offering surveillance or consultation in either the reception class or Year 1. Thirty-three per cent reported surveillance and consultation, a further 10 per cent surveillance only and 33 per cent consultation only. In total, 23 per cent of the schools reported neither service. However, 79 per cent of schools reported hearing and sight tests in both or either years; 9 per cent had a hearing or sight test once during either of these two years, and 12 per cent reported that pupils in these years had had neither test. Overall, forty-five schools (8 per cent) reported neither tests for hearing and sight nor whole class surveillance or consultation. A further 3 per cent reported only minimal service, either a hearing or sight test. At the other end of the scale, 31 per cent of schools report both surveillance and consultation and hearing and sight tests.

We invited suggestions for improvements to the SHS and one-fifth made some comment on the quantity or quality of the SHS's medical input. Some were straightforward acknowledgments of the limitations imposed through lack of time:

> SHS staff are understaffed and it would seem the greatest improvement would come about by employing more people so that they do

> not have to rush around so much. (Rural primary school with fifty-six children)
>
> Like education staff they have insufficient time to extend their work, e.g., last year's annual screening in reception class was delayed because no doctor was available. (Town infant school with 102 children)

Some commented directly on the quality of the testing:

> Sight tests should not be with letters of alphabet for many young children newly exposed to English language. Letters should not be upper case. Hearing tests need to be more frequent. Speech therapy needs to be done in school and the clinic. (Inner-city infant school with 260 children)
>
> Doctors — the medical examination seems very limited particularly when reporting on special needs children. Occupational therapists referral — virtually doesn't exist. Speech therapy — seems to be consultation only. How can schools cope? Audio tests are annual — children can miss it. (Inner-city junior school with 290 children)

Other comments centred on the type of service offered, including specific requests by eleven schools for reversion to the traditional universalist service:

> We do not like the new interview assessment by the school nurse. We prefer the doctor to medically examine all children. We now have three different systems (not including those who refuse) doctor, assessment, eyes only. (City infant school with 220 children)
>
> More screening — children can now get through school without any contact with SHS at all. (Small town infant school with 109 children)
>
> The provision in years gone by has been far greater. Indeed there are relatively few checks on all children. The school clinics as we knew of them were far more valuable than anything on offer now. (Inner-city primary school with 310 children)
>
> We have an excellent dedicated school nurse but she doesn't have enough time — she covers other schools too. Nits are an ongoing issue. Please can we have the nit nurse back. As well as the health issue they have spin-off effects affecting social relationships in school. (Large town primary school with 290 children)
>
> Reintroduction of whole class surveillance for head lice, scabies, impetigo, etc. (Inner-city primary school)

This latter point about head lice and head inspections was raised by thirty-five schools, all requesting the return of regular checks and the involvement of the school nurse in dealing with the problem. This large rural infant school was contemplating 'going private' to deal with the issue:

> Investigating possibility of employing nurse to make head inspections (at school/PTA expense) as this is a contentious issue. (Rural infant school with 415 children)

SHS Role in Health Education at School

Table 1.16: SHS input into health education by class/year and topic (%)

Health Education Topics	*School Year*						
	Reception	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Physical development	8	9	9	6	6	12	27
Diet, healthy eating	4	5	5	4	11	3	3
Personal hygiene	11	12	12	12	14	10	13
Sex education	—	—	—	—	1	10	25
N	524	532	532	502	486	456	454

School nurses are encouraged to believe they have an important part to play in health education (Nash and Thruston, 1985), a view confirmed by the Health Visitors' Association (HVA) (1988) and endorsed by the nurses we interviewed in the case-studies. However, Table 1.16 indicates that the SHS input into the health education curriculum was small. This may in part reflect the fact (as noted in the section on Health Education, pp. 51–3) that many schools approach health education as a cross-curricular topic or opportunistically, so there may be no obvious or convenient 'slot' for nurses. Local health authority policy, in emphasizing medical over health education work and in cutting services, will reduce not only nurses' availability but also the chances of good nurse–school relationships. However, it is noticeable that SHS input to health education increased somewhat in Year 5 and markedly in Year 6: these top classes had more input, mainly on bodies and sex education. In their comments on possible areas for improvements in the SHS service, only 9 per cent of schools made suggestions relating to the role of the SHS in the classroom, which reflects the traditional distance between the teachers and SHS staff.

This large town primary with 360 children would like to see:

> More direct involvement at classroom level especially in EPR/Sex education programmes. Teaching aids provision. Published material for parents.
>
> Need to have more input into PSE curriculum by attending inset and more nurse involvement with the children during school time, i.e., talk during assembly, input into class lessons. (Rural primary school with 351 children)

Some schools thought school staff were responsible for enlisting SHS input to health education:

> We ought to be more pro-active in encouraging them in and using them.
>
> Pressures of other areas of the curriculum prevents this. (Town infant school with 150 pupils)
>
> Our school nurse has offered to input into lessons. Teaching staff perhaps forget to make use of her. (Town junior school with 250 children)

Allocation of scarce time resources were noted by these two schools:

> More time for the school nurse to spend with classes of children — often this work is being done in her 'free time'. (Rural primary school with 230 children)

But perhaps the SHS should be concentrating on its medical input rather than on education:

> Nits [have become a problem] since school health service turned its attention to education. (City infant school with 180 children)

Liaison between the SHS and the School

The SHS and the education service operate as separate services at every level, from ministries down to school level. And though reports routinely stress the importance of liaison, it is up to individual authorities and agencies, and up to individuals at school level, how much and what kind of liaison takes place.

Table 1.17 Percentage of schools having procedures for liaison between SHS and school and between SHS and parents

	Agreed procedure	*Informal procedure*	*No procedure*	*Missing*	*N*
Liaison between SHS and					
Headteacher	53	43	3	1	620
Teachers	29	53	8	10	620
Parents	54	29	8	9	620

We asked whether there were agreed procedures or informal liaison arrangements between the two sides. Whilst 86 per cent of schools reported such arrangements with the headteacher, only 53 per cent reported an agreed arrangement. Liaison arrangements between the SHS and teachers were less likely to be agreed, with under one-third having agreed arrangements and over half relying on informal liaison. These answers may simply reflect the formal position and may not relate to practice within the school. Teachers may be adequately informed by the headteacher, and/or may have adequate informal working relationships with SHS staff, but, as noted above, this may depend on personal initiative (Mayall, 1994a). Comments pointed to liaison difficulties for schools:

> The teaching staff do not have enough time to liaise with SHS staff. Teachers need to be made more aware of the support SHS staff can offer. (Rural primary school with 176 children)
>
> SHS to work to a written agreement for the year group screening (dentist audiometrician, full medicals, etc.). SHS to provide up to date list of personnel and contact times with telephone numbers. (Small town infant school with 275 pupils)
>
> More direct liaison — although I accept the confidentiality problem. A more clearly defined role for the many agencies/trusts/professionals who may be involved. Not for our further information but for parents who often become confused. (Small town primary school with 192 children)
>
> Meetings between headteachers and school doctor need to be fixed as an official diary appointment. So often time has to be snatched to discuss results of medicals. (Infant school with 321 children)
>
> Names of children to be examined should be sent to me before selection visit so that I can talk to staff prior to the visit. (Rural primary school with 102 children)
>
> More communication from the medical profession when dealing with children to allow school up-to-date information. We rarely know what is going on even if we have started an investigation/treatment referral. (Large town primary school with 218 children)
>
> I do not like the amount of time my secretary has to spend on admin for the SHS — sending letters etc. (Rural primary school with 138 children)

Several schools commented on the lack of liaison between the SHS and the other agencies. This small town primary school with 234 children implicitly noted the desirability of co-terminosity:

> Place the school in the same health authority as it is for social services support, etc.

Respondents' replies on SHS liaison arrangements with parents indicate further inadequacies: 54 per cent reported agreed procedures, 29 per cent informal liaison and 8 per cent (fifty-one schools) none; 9 per cent did not respond to this question. Of the fourteen schools which responded that there were no agreed procedures for liaison between the SHS and head, teachers or parents, only two commented on the need for more liaison or feedback. Possibly these answers reflect lack of knowledge amongst some of our respondents about liaison arrangements. However, whether there are no agreed procedures, or whether schools do not know if there are, these answers must give cause for concern. The division of responsibility for the care and education of the children between two sets of professionals may lead to inadequate liaison both within the school and across the home and the school, and to children's health problems not being recognized and dealt with at school.

Only 11 per cent of schools mentioned some aspect of SHS–school liaison in the suggestions for improvement section. This small percentage may reflect the traditional distance between the education and health services. A further relevant point is that it was heads who filled in the questionnaire, and it is with them that the SHS mainly liaises, as indicated earlier in this section. Teachers and parents tend to wish for improved contact with the SHS, as our case-studies show.

Satisfaction with SHS Input and Contribution

We asked schools if they were happy with the contribution of the SHS to the health of the children and to the school more generally. Overall 62 per cent said that they were happy with the former and 58 per cent with the latter; and 27 per cent reported some problems with both. Few reported unhappiness as regards contributions to the children's health and to the school generally (7 per cent and 8 per cent respectively). These answers may reflect sympathetic recognition of difficulties caused by reductions in SHS staffing. But possibly they also reflect the view that the SHS is not essentially concerned with the maintenance and promotion of children's health at school.

However, not surprisingly, satisfaction was significantly linked to frequency of visits from SHS staff. Those schools which had a weekly visit from the nurse expressed the highest rates of satisfaction, and dissatisfaction was much higher in schools where the nurse visited only once a term or less. Staff turnover was also relevant to satisfaction, and turnover in nurses significantly so. Thus, 70 per cent of those reporting no change in the nurse were happy, but of those who had had three nurses in the last three years only 37 per cent were happy; and 22 per cent were dissatisfied. This finding is in line with the general view that it is the nurse who is the most important SHS representative in the school, as the more frequent visitor and as a person who sometimes takes part in school work — in health education. The presence or absence of liaison procedures was not related to satisfaction.

A few schools commented on the lack of communication on a wider level between the health authority and the education service:

> The health authority rarely consults schools. There is no mechanism for schools to be consulted. The only occasion in my 25 years' experience that the health authority asked schools' opinion was by a market research [questionnaire]. Consultation is a dialogue and needs interaction between the parties involved but neither side has the time or resources to allow dialogue. (Rural primary school with fifty-six children)

Some comments raised the issue of professional behaviour:

> They need to be better organised. It's no use telling us twelve hours beforehand that they want to come in and check 30-plus children the next day. If they make appointments to see staff, parents and specific children they should keep to them or at the very least let us know if they are not able to keep the appointment. They are not professional. They make notes on scrappy pieces of paper which they lose. (Small town junior school with 249 children)

However:

> Under the constraints they have to work with, our SHS does a good job. (Small town primary school)

> We are lucky, we have a great school nurse who is always ready to work alongside staff and join in school health initiatives. (Rural primary school with 88 children)

> We consider the school doctor and nurse to be invaluable. They have paediatric expertise and knowledge of the families — their service is essential for the 'care in the community'. We support the SHS and see the support as different to a normal GP's role. We wish this service to be extended to increase health issues education throughout the whole school. (Small town primary school with 140 children)

Contrasting views were expressed about how far the SHS should be involved in health care. Not all supported the views of the above school, although one argued for a much more substantial role for the school in primary health care:

> It seems regrettable that more of the monitoring of babies' and children's health cannot be based within the school building. The local baby clinic, health centre and doctors' surgeries are quite a distance for our pupils and parents resulting in high 'PNA' (parent non-attendance) of appointments. The school building would provide the health service with a 'captive clientele'. (Inner-city primary school with 249 children)

Opposing views were expressed by some who questioned the value of the SHS; for instance, a large town primary school with over 200 pupils argued

> I feel their tests for vision [are] very crude and wonder whether they really do pick up those who need to be offered proper eye tests. I also feel that the school doctor's role monitoring specialist treatment [is] often superfluous. GP really seems to be more appropriate.

This point was repeated by this small town infant school with 225 children:

> Regular monitoring of Reception year pupils by School Medical Officer rarely picks up problems not already recognised by home/school.
>
> Have all health matters dealt with outside school. Have pre-school checks made for 5-year-olds before they start school. (Rural primary school with eighty-seven children)
>
> We are lucky and have a good partnership. It does seem, however, that those involved in managing the school nurses are determined to focus on advisory issues rather than on involvement with children, e.g., advise on policy and curriculum. Whilst this is welcome there is still a role for the school nurse to check the general health, hygiene and development of all pupils. If they don't do this job, then who will? (Junior school in large town with 128 children)

School Health Service — Overall Assessment

We created an SHS index which included six topics: the frequency of the nurse visits, whether the same nurse stayed in post, the availability of a specified room (or one shared with the first-aid room), satisfaction with the service provided and the character of liaison between SHS–school and SHS–parents. (See Appendix 3 for details.) As with our other indexes, this combines topics out of individual control, as well as those (liaison) where individuals may — time permitting — affect the service.

There was a fairly even distribution of schools across the index, with 24 per cent scoring up to zero, 19 per cent one, 22 per cent two and 28 per cent four or more. We found no significant differences between schools according to location, size of school or age-range. The huge range in the character of the service and satisfaction with it, together with the understanding and sometimes angry comments, must mainly reflect local health authority policy and practice.

In sum, our findings on the SHS reflect the absence of structural relationships between the SHS and the education service. The services are staffed and structured in parallel, yet a good service requires policies to ensure contact between the three principal sets of people — SHS staff, school staff and parents — if children's health problems are to be adequately addressed. In practice, adequacy of contact will vary according to history, local initiative and personal effort: in our survey, the SHS had agreed liaison procedures with the school and with the parents in only half of the schools. SHS work in schools has low priority with both the education and health service. Thus education planners provide a SHS room in very few schools. Within the health service, work in schools has low status, and turnover in staff reflects this situation. And although SHS staff have knowledge and skills which could be a valuable resource to help with schools' health care and health education activities, few schools are managing to work together with health staff to maximize their contribution. The large workloads of both SHS staff and teachers, and SHS staff turnover, probably inhibit the establishment of good working relationships.

More generally, it seems that whilst health service organizers may be reducing or restructuring services, schools think the old universalist service was better than the new. Certainly 36 per cent of our 620 schools suggested how improvements could be made to the service; most of the suggestions (20 per cent of 620) were for increased medical input, with 9 per cent arguing for more input to classroom work and 11 per cent for improved liaison. Comments here, and elsewhere in the survey, indicate respondents' recognition of increases in poverty-associated ill-health amongst their children which required input.

8 Input to Schools

We have described the participation in the life of the school of a number of types of people and agencies. These include: parents and other interested local people; health educators; caterers; the school health service. Yet to be discussed here is the local education authority (LEA). The input of the many participants may be considered in the context of three broad themes:

- with whom does responsibility lie for the amount and character of individuals' and agencies' input to the life of the school;
- how far does the input operate for the children and how far for other purposes;
- what is the division of responsibility for children's health status between school staff and these individuals and agencies, and how clearly is it spelt out.

LEA Input

We start with some comments on the LEA's input. Generally, the health and safety of employees is the responsibility of employers. In schools, it is staff not children who are employees and the LEA is the employer. So commentators, as well as individuals in the education field, have to consider how the law works as regards children. Croner (Primary Education Directory, 1993, p. 5) notes that 'who is responsible is a thorny question' but that the head, as the person in charge of the workplace, and the governors, with their increasing responsibilities, must be held responsible; they cannot assume that they can 'take refuge' behind the 1988 Education Reform Act's assertion that the LEA is finally responsible — although many LEAs do retain responsibility for some aspects of premises. According to the Health and Safety Commission (1995, pp. 1–5), in the case of maintained schools, the responsibility for staff and children lies with the education authority; it may require the school to work up a health and safety policy, and the governors will be expected to monitor and review its operations. The head will be responsible for the management of the policy on a day-to-day basis.

Under the current LMS arrangements, LEAs devolve some financial responsibility for health and safety matters to school heads. Allocations are worked out on the basis of pupil numbers (rather than on indications of school need). Exactly what division of responsibility is arrived at varies between LEAs. Overall, though, LEAs remain responsible for large-scale aspects, such as structural repairs and alterations; schools increasingly carry out minor repairs (NUT, 1990).

Among our survey schools, 36 per cent reported that their school had received inspections on health and safety matters from the LEA during the preceding twelve months, 63 per cent had received written guidance or advice and 32 per cent had received input from the LEA in the form of modifications, improvements and/or repairs. However, over a fifth of schools (21 per cent) reported no input from the LEA in that 12-month period. The extent of the LEA input did not appear to differ by location or by the age of the school building, although size did seem to be relevant: 39 per cent of schools with 300 or more children reported repairs or modifications. Perhaps this was because there was more building to repair!

Many respondents had reservations about the adequacy of LEA input. Overall, 26 per cent rated the input as poor or very poor, 44 per cent as average, and 30 per cent as good or very good. Schools' ratings may reflect their comments, which show understanding that LEAs are short of funds. However, the ratings varied with the input reported as received by the school. Only 9 per cent of those reporting no input rated the LEA input as very good or good compared with 42 per cent of LEAs whose schools had received repairs or improvements. Equally, 50 per cent with no LEA input but only 18 per cent of those receiving repairs or improvements rated the LEA input as poor or very poor.

Feelings about LMS were mixed, some schools referred to grey areas of responsibility, some noted the unfairness of being landed with a poorly maintained building; others thought it had given them autonomy to deal with their own problems.

> We have requested money from the LEA to improve the fittings in the toilets, e.g., cracked seats, no chairs, loose toilet roll holders etc. We have now financed the urgent repairs ourselves. (Rural primary school)

> Extra classrooms (waiting DFE approval). New toilets (estimated cost of replacement given 18 months ago). Constrained by lack of finance. The building is cramped and rather poor. Toilet facilities are outworn and insufficent. Local management of schools has placed an unfair burden on small schools. With budgets determined by pupil numbers this has led to larger classes, a lower standard of building maintenance and general cost-cutting. (Town primary school)

> LMS has helped the school address issues of poor maintenance of buildings. Decoration fixtures and fittings. However the legacy of previous poor maintenance by LEA meant that it will take some years before a rolling programme can be completed, e.g., school decorated and furnished, a medical room. (City infant school)

> LEA has dealt with all requests for improvements to health and safety very promptly. (Small rural primary school)

> The [LEA] health and safety administrator re buildings etc is excellent. (Large town infant school)

> Under LMS we have bought into Property Services and Advisory Service but still have to find monies from small budget which depends on the number on roll not the age of the building. (Town infant school)

> Refurbishment of boys' loos — summer 1994. Small extension to existing classroom to improve provision for 4+ part funded by LEA, part funded by PTA. The PTA is always involved in self-help and incentive schemes to improve building facilities, e.g., apparatus. (Town infant school)

Thus the data suggest that areas of responsibility between the LEA and the school are unclear in some cases, and schools may have to negotiate and have recourse to other sources of funding. Levels of dissatisfaction reflect this situation. Clearly the LEA's input is conditioned by larger-scale interests and constraints than unswerving attention to the (often dire) needs of the school — judging by the descriptions of unsafe and unhealthy schools we received.

Agencies and People — Input to Schools

A similar set of points emerge in considering catering and the SHS. In both cases, what these services provide is not necessarily tailored to the general or specific health-related needs and wishes of schools, but to the interests of the agency. Caterers have to be financially viable, and so may sell junk food to children rather than only healthy food. The SHS serves public health interests — identifying and referring problems — rather than offering a service to children, and current medical thinking (e.g., BPA, 1995, Chapter 5) emphasizes policies that target children defined as 'in need'. Whilst catering and SHS staff may individually wish to give children a good service, the policies and organizational constraints within which they work control the level and quality of service. Schools may negotiate for a better service, as we have noted, but they have little power to improve the health-related aspects of SHS provision; though they do have some power to collaborate towards more healthy menus.

An important resource for schools is parents and other local people who may carry out some of a huge range of functions at school: helping in class, teaching computing, swimming or health education topics, doing secretarial and DIY work, and fundraising. Here the school does have some power to recruit and to ask these people to work in the school's interests, and towards the academic, social and health-related goals of the school. However, as we have noted along the way, school teachers' traditional suspicion of parental knowledge and motivation remains important and may be a stumbling block to collaboration.

When we asked schools to list problems they face (F3, see p. 240), 23 per cent of the 620 schools made adverse comments on parents and their ability and willingness to care well for their children. Similar suspicions are to be found in the case-study data. So though parents are an important resource, tensions of a general and individual kind may deter parents from helping the school. In addition, not all parents see it as part of their remit to help schools and, in areas where they face problems associated with poverty and unemployment, they may have little energy or time to spare. Recruiting other local people, probably depends largely on staff's local knowledge and contacts, but also on the extent to which local people and agencies regard the primary school as an appropriate focus for their concern and input.

Using survey data, we constructed an index relating to input and the liaison procedures in place. These were: regular unpaid help in school in three or four areas; the existence of a Parent–Teacher Association (PTA) or similar organization; two or more outside speakers doing health education sessions; SHS–headteacher formal liaison; SHS–parents formal liaison; policy discussions on school dinners; and a good or very good rating for LEA input. The maximum possible score on this Input and Liaison Index was 7. (See Appendix 3 for detail.)

There was a fairly even spread across the scores, with 19 per cent scoring 0–2, 28 per cent scoring 3, 21 per cent scoring 4 and 29.5 per cent scoring 5, 6 or 7. The only significant difference betwen schools was that more of the rural schools, whether small (under 200 children) or large (over 200 children), scored 5 or more: 38 per cent did, compared to 19 per cent of inner-city schools and 29 per cent of city and town schools. At the other end of the scale, 13 per cent of rural schools scored 0–2, compared to 20 per cent of small town schools, 22 per cent of city schools and 27 per cent of inner-city schools. (See Table A3.5, p. 249.) Perhaps rural schools function in a 'community', where the school is a central feature of local life, and contacts are better established and more personal. One rural primary school with eighty-eight children described itself as a 'small village school with strong community spirit' and another, with forty-four children, noted a particular strength of the school as 'knowledge of and close relationships with children and their families'. And services in rural areas, though they may be stretched, are not faced with the scale and character of social deprivation to be found amongst children and their families in city areas.

Infant schools also scored significantly lower than junior and primary schools on the Input and Liaison Index. This may be because they had less regular unpaid help, and also did not use outsiders for health education — since the approach in infant schools was largely opportunistic and cross-curricular. Whilst staff and parents may commonly regard the infant classes as the ones where teacher–parent relationships are closest, the index points to another view of the infant school — as a world where class time is in the hands of staff, rather than shared with parents and other outsiders.

Here we quote some points made on questionnaires by schools scoring respectively low and high on the index. Within these categories, we have chosen schools which offered substantial explanatory comments on their answers.

This inner-city infant school with 260 children, scored only 1 — for SHS formal liaison with the headteacher. As the headteacher noted: mobility of families was a problem, 'many children stay a very short time — 6 months or a year.' Not surprisingly, the school had no PTA and no regular help with school activities. 'Many families have not had access to health care until they come here, from Somalia, Bangladesh, Zaire.' This point links to dissatisfaction with the quantity of the SHS input (rated very poor). Though the nurse visited weekly, this was not enough to deal with health problems; the doctor visited three times a term. Liaison was formally with the head, but only informally with teachers and parents. The SHS should offer more input on 'diet, clothing, care, good habits, play etc'. The SHS sight tests were described as ethnically inappropriate — using letters of the English alphabet. More frequent hearing tests were needed. The school itself offered advice to parents on housing and domestic problems. The school had input in the last year on health education only from the police — not from the nurse (who ran sessions in 79 per cent of schools). The school had no liaison with the LEA catering service, and rated the dinners average on quantity but very poor in quality — all the more deplorable, as the headteacher noted, since most of the children had free school dinners. The LEA input was rated very poor, a rating which reflects not only the very poor state of the main building 'built 1921, asbestos, leaks, rusting windows, rotting timbers, blocked drains', but also the LEA recommendation that no more money should be spent on the building. 'No money has been spent for many, many years.' Some repairs were carried out in the last year. The headteacher concluded, 'Our working environment here is poor. We lurch from one crisis to the next. Thank goodness I have excellent staff and most parents are supportive.'

At the other end of the scale, this large town junior school with just over 200 children scored 7, the maximum on the index. The school had a PTA and had high input into school activities: in class, on trips, with fundraising and with making materials for school use. It had also had high input into health education from the school nurse, other health professionals (a chiropodist was cited) and the police. The SHS had formal liaison with the headteacher, though only informal liaison with teachers and parents, and its input in quantity and quality was rated good. The nurse reportedly visited regularly, as required. The doctor visited once a year and there was no dentist. The LEA provided the school dinners which were rated good in quantity but only average in quality, though the school had policy meetings with the caterers. 'School meals could be healthier,' the headteacher noted. The school was housed in a 'modern' building (1944–65) and LEA input was rated very good: they had inspected, given guidance and made improvements and repairs in the last year. The headteacher noted that close liaison with parents and health service personnel 'with the school as a focus' was a particular strength of the school.

Finally, this rural primary school with 260 children scored 6, losing a point only on the LEA input — rated average: inspection and some improvements had taken place in the last year. The school had a PTA and help with swimming, school trips and in class. The school nurse, police, coastguard and fire officer had taken part in health education sessions. Unusually, the SHS had formal liaison arrangements with the head, teachers and parents. The school held policy discussions with the caterers and rated the meals good on quality and quantity. The building was modern and all aspects of the physical environment were rated as good or very good. It had a 'very supportive and well-to-do local community.' On strengths of the school, the respondent noted 'good home–school relationships; good relationships with support agencies; good and effective links with local GPs'; and attributed school satisfaction with the SHS to 'mutual respect and professionalism'.

These three examples point up some general issues. Firstly, service provision by the LEA, SHS and catering lacks consistent standards. Secondly, services are not tailored to the needs of schools; therefore, disadvantaged schools do not necessarily attract compensatory input. Thirdly, the ability of schools to recruit unpaid help will depend not only on their own efforts but on the character of the local population — in general, hard-pressed parents can and will offer less than well-to-do parents. Fourthly, schools' ability to provide children with a good service depends on a wide range of services and individuals. This point was developed by the Infant headteacher in relation to support services for children with special needs (see pp. 219–20). Yet schools find that services do not appear either to aim for or to implement health-related goals, a point forcibly expressed here:

> It would be helpful if schools had some formal written indication of how both LEA and SHS see their role in promoting and supporting health care in schools. (Small town infant school)

This headteacher draws attention to the absence of coordinated policy and practice in relation to the maintenance and promotion of children's health at school.

9 Commentary on the Survey

The survey aimed to provide data on some key topics which would enable us to consider how children's health is conceptualized and treated in primary schools. We are interested in the status of health as a topic in schools, in identifying the key workers and studying the division of labour between them, and in children's opportunities for health maintenance during their school days.

The data were provided by adults, and they consist of factual answers (such as, numbers of children, frequency of SHS visits); opinions (such as, ratings of the playground or the contribution of the LEA); and there were also opportunities for open-ended commentary. We emphasized in many questions that it was the school as a physical and social environment for the children that we wanted respondents to consider. And though the data are from adults, they do allow us to reflect on that topic. Children's own views were studied in the case-studies. (See especially Part Three, 'The View from the Children'.)

The status of children's health in primary schools is the basic issue in this research, addressed here, not directly through questions, but in the light of the range of data collected. First, we consider the availability of staff and the character of the physical environment.

Staffing and the Physical Environment

Obviously the central remit of primary schools is to teach some basic skills and impart some knowledge, increasingly nowadays within 'subjects' listed in the National Curriculum. As regards the care of the children, it can be said that the psychological child rather than the physical child is at the forefront of teachers' priorities (see, for example, Hendrick, 1994). Nevertheless teachers and other staff in schools regard themselves as caring people who take due account of children's physical as well as emotional needs as expressed by children and as assumed by staff. Further, in taking children compulsorily into their charge, school staff have a duty to care for children, in place of their parents.

Staff ability to care for the children will depend somewhat on adult–child ratios, and our survey described the range of these, whether one considers teaching staff, other staff or both together. The ability to know each child well, to monitor their health status and to respond to children's requests with offers of help and comfort, must relate to the sheer numbers of children each adult has to deal with. In our survey, children's chances of teacher-attention varied:

in some schools (13 per cent) children competed with up to fourteen others, in others (10 per cent) with twenty-four or more. Children in the smallest schools had the best chances of adult attention.

Providing a suitable physical environment is also critical if children are to stay healthy at school, work well, and play well, both in PE sessions and at playtimes. The division of responsibility between the LEA and the school appears to vary across authorities, but LEAs generally retain responsibility for the buildings and structural matters. It would seem that many LEAs, for whatever reasons, put the maintenance of healthy school buildings and outside space fairly low down their list of priorities, if we are to judge by the high rates of dissatisfaction recorded on aspects of the physical environment — including, the building itself (rated poor by 22 per cent), play equipment (44 per cent), and the toilets (21 per cent). A report on poor standards in toilets and on increases in hepatitis A (jaundice) and dysentery suggests links between hygiene and illness (*The Teacher*, 1992).

If we look at literally structural factors affecting children's opportunities for health and health restoration, we find that the provision of medical and first-aid rooms by the planners and architects is variable, and though more of the more modern buildings than of the older have them, by no means all do (cf. Maclure, 1984). In older schools, built before the Second World War, an asphalt playground was commonly all that was provided for play and PE. Perhaps planners and architects once thought such provisions were adequate, but nowadays neither staff nor children think their legacy is suitable for children's daily lives. Children's chances of safe active play, and of quiet and private space to rest, are conditioned by the long shadow of history.

Finally, health and safety in schools can be regarded as low priority if one considers the legal situation. Whilst employers are required to provide first-aiders (at the rate of one to every fifty employees), this does not apply legally to schools. Yet children are as likely as anyone else to be ill or have accidents, if not more so. In only 39 per cent of schools had anyone ever taken more than a short first-aid course, and in 13 per cent of schools no-one had done training of any kind. We know (from respondents' comments) that though LEAs and other bodies provide courses, lack of time and money for these is a deterrent at school level.

The Key Workers and the Division of Labour in Health Care

Whatever may be the merits or demerits of the physical environment, the input of a large range of people determine the character of the health care in each school. And if these inputs, whether within the formal or informal system of the school, are to be effective, liaison between the various adult groups is probably important, if not crucial. Schools in our survey varied widely in the priority they gave to health issues, if we judge by some of our variables.

The division of labour for the hands-on care of children appears to favour the non-teaching staff, since higher proportions of them had done some first-aid training compared with teachers. The liaison between these two sets of staff is a topic for investigation in our case-studies. As every mother knows, the division of labour in case of illness or accident deemed serious by the school, favours handing the child back to the 'parents', in practice usually the mother. Our data on accidents indicate that arrangements for contacting them were good.

Whilst some schools had appointed coordinators to oversee and devise health education and health promotion policies and practices, others had not. Whether or not schools had coordinators, few claimed to promote healthy behaviour through specific policies. Similarly, though a majority had guidelines for the care of ill children and in case of accidents, a quarter had neither. This is not to say that those schools did not operate effectively, but these variables do provide a crude indication both of the status of health issues within a school, and of the likelihood of efficient collaboration and liaison.

As to the SHS, whatever may be the views of the medical establishment and policy-makers as to the appropriate level and type of input, 38 per cent of our respondents expressed dissatisfaction with the SHS contribution to the children's health status, and dissatisfaction was linked to low numbers of visits from the nurse. Slimmed down, cut-back, selective services were seen as failing the children, whose problems might be missed. Teachers also noted, as did those in the case-studies, that they got inadequate information and advice on special needs and on chronic conditions (affecting at least 13 per cent of children in the case-study schools).

We also studied liaison — between the school and the SHS; between the school and parents and the local community more generally; between the school and caterers; and between the SHS and parents. As with other areas, it seemed that high proportions of schools operated only informal arrangements, no doubt established over several years. The SHS generally related to the head, rather than to class teachers, and (if our informants are correct) it had informal arrangements to contact parents rather than defined procedures. Most schools had PTAs and were receiving help routinely (probably mainly from mothers?), but most schools did not harness local skills to help with health education. Of particular concern is the absence of policy discussion in most cases between the school and caterers.

Children's Opportunities for Health Maintenance, Care and Treatment

Here we consider the data even more directly from the children's angle. The issues here are whether children attending our primary schools are likely both to receive good care, and whether they can, as contributors to their own health status, participate in the management of their daily lives so that these are as healthy as possible.

The survey shows that children varied in their access to adults, according to adult–child ratios. If, as is widely reported, these ratios are worsening, the implications for children relate not only, as the politicians debate, to teachers' ability to teach children effectively, but to children's contacts with adults for care and advice. More children in each classroom and in the playground also means overcrowding — with consequent discomfort, including noise, minor ill-health from headaches and colds, and, almost certainly, more accidents.

The toilets and cloakrooms are an important part of the social and physical environment for children, and poor facilities can mar their experience of daily school life. Again, respondents were satisfied with these in less than half the cases, and indeed the building itself and the toilets received the lowest good ratings.

As regards the opportunity to choose healthy food, we have reported a mixed picture. On the one hand, very few children (11 per cent) reportedly had the chance to participate in discussions about menus for school dinners. Probably they had a choice of foods, but only within what was on offer, including the junk food caterers feel obliged to provide. On the other hand, they were allowed to bring packed lunches so they and/or their mothers could choose the contents. Some schools encouraged the consumption of healthy foods in packed lunches and in snacks, but about half did not.

Children's opportunities for exercise and play were also mixed, with playgrounds and especially play equipment receiving poor ratings in 18 per cent and 44 per cent of cases, respectively. Though, according to respondents, staff made up for poor physical provision by promoting adequate exercise as part of the curriculum, we have to ask (in the case-studies) whether children themselves experience enough exercise and play during their day at school. The quality of experience is also important and a small, crowded, hard surface playground will probably engender more accidents than spacious grounds with some grassed areas, and designated areas for specific play activities.

The opportunities children had for good care in case of illness and accident are difficult to assess, since they will result from a combination of physical facilities and adult input. Pressures on teachers from increasing numbers of children and from the demands of the National Curriculum may reduce their ability to respond appropriately to children's sickness bids. As we have noted, schools tended not to have a sole-use room where children could be cared for and rest, and supervision in such a room is difficult when there is no staff member with specific responsibility for it. Since schools had made sure they could contact parents, children were likely to be returned to their mothers' care in case of serious conditions; this, judging by our case-study children, suits both mothers and children.

Finally, we note that most children did not have ready access to a health professional, as a source of information and advice. Visits by SHS staff were generally fairly rare, and their purpose was mainly identification of problems in order to refer them. The school nurse, whose recommended remit includes a service directly for children, gives widely varying numbers of visits to schools — in only 17 per cent did she visit as much as once a week.

Health Maintenance in the Social Organization of the School

The survey explores territory which, as a whole, has otherwise been largely unmapped though some individual features of it have been the subject of enquiries. In order to conduct this exploration, we have crossed a number of boundaries. Thus the survey considers:

- the contribution of a range of services to the school as a health maintenance establishment — the education, school health and catering services;
- intersections of structure and agency — social policy, the physical environment and adult input — and how these impact on the social and physical health-related context of children's daily lives;
- both the formal and the informal curriculum of the school — its teaching, policies and practices;
- the contributions of teaching staff, non-teaching staff and paid and unpaid individuals, including parents.

These considerations amount to describing a primary school as an extremely complex social organization, where a huge range of interlocking factors go to make up its particular characteristics as an environment for children's daily lives. It is equally a large and complex task for service-providers at agency and individual level to think about tackling health-related features of children's daily lives at school. Given that many decisions are out of the hands of local agencies and individuals, the task is even more formidable. In the case-studies of six schools, each with its own complex set of characteristics, we explore in more detail the school as a health-promoting environment for children.

Children's chances of well-being, including their own opportunities to establish and maintain a healthy way of life at school, will depend on all the above factors, and also on their opportunities to maintain some autonomy within the formal and informal activities and social norms of the school. Important here are children's rights to participate in decisions about matters that affect their lives and to have their views taken into account. Through the study of data from the children themselves, we hope to contribute to knowledge on these topics.

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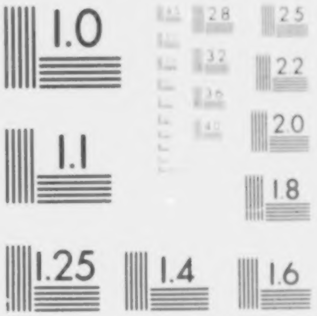
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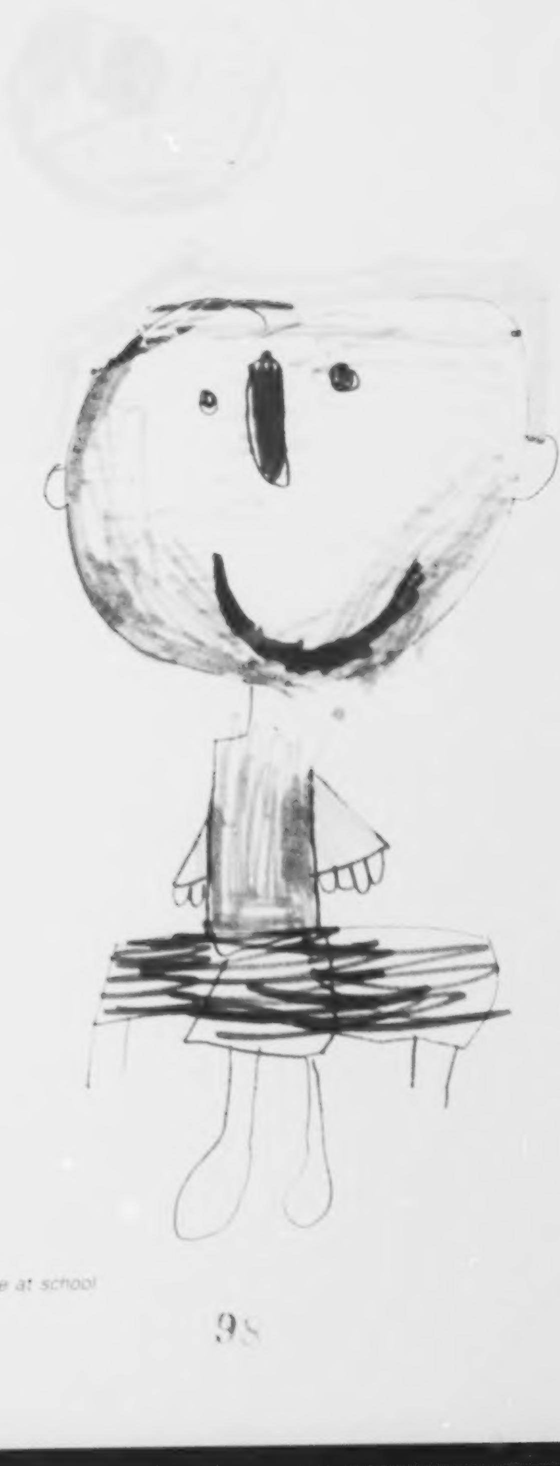

Plate 2 Me at school

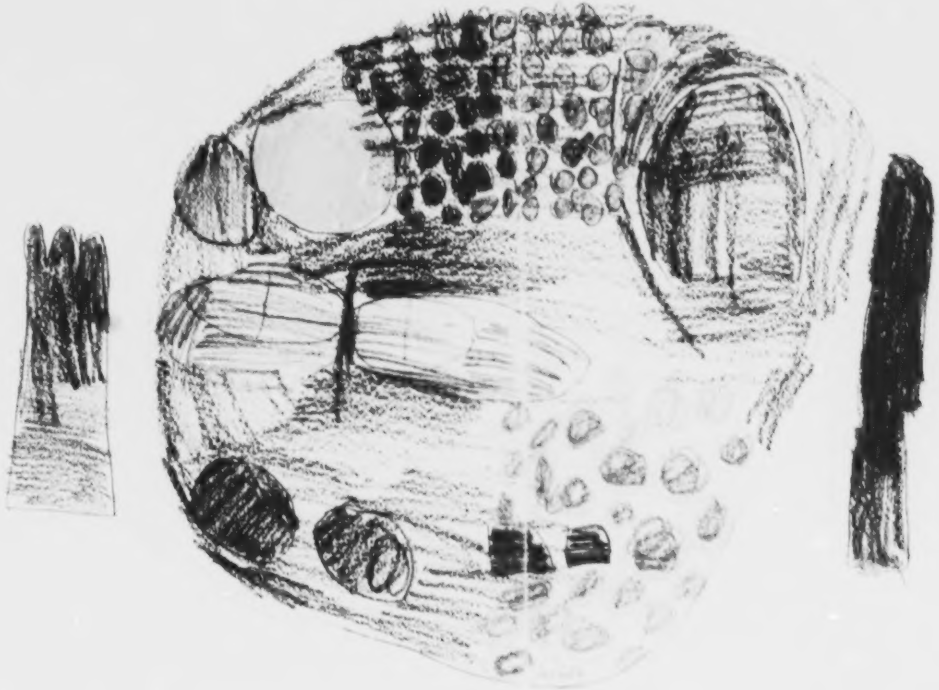

Plate 6: School dinner

Part II

The Case-studies

Preface

Aims of Case-studies

This second part of the book consists of six chapters, each with a case-study about one school. The broad aims of the case-study work are three. The first is to provide fuller data on the topics set out in the questionnaire and reported in Part One. This we have done through discussing the topics with staff, which allows us to complement, deepen and give fuller meaning to the topics. Secondly, the case-study data illuminate some of the ideas that underlie schools' policies and practices:

- What are the physical and social characteristics of the schools and what measures have schools taken to modify these? What are the factors enabling and/or restricting such actions?
- What is seen as the appropriate division of labour between adults for the care of the children?
- How satisfied are staff, children and parents with present health-related policies and practices in the school, and what factors are seen to facilitate and impede good policies and practices?
- How far do the various actors think children do, can and should participate in caring for themselves at school, and what part do and should children have in discussions about school policies and practices that affect their well-being and health?
- What do schools think is and should be their relationship with the local community?
- What, finally, is the status of children's health at school, in the light of the many factors that affect policy and practice?

Thirdly, we aim to widen the range of perspectives on the school as a health-maintaining environment by discussing relevant issues with children. This work has focused on children aged 6–7 years, and children aged 10–11 years. Thus we have included children who are established in school (having completed a reception/Year 1), but still in the early years, and children at the top of the primary years, who can look back over their careers as well as reflect on their present experiences. We also attempted to raise some of the health-related issues with parents, through group discussions and questionnaires.

The Case-study Schools

The choice of schools for the case-studies depended on a number of considerations. We could not include among six schools a representative sample, in the strict sense, of our questionnaire sample, but we did aim for variety. We planned for large and small schools; infant, junior and all-age schools; in inner-city, town and rural areas; in well-to-do and more socio-economically deprived areas; and in a range of geographical areas. It was also important to look for schools which were reasonably convenient for the researchers. And though we did approach some schools, cold, we also used personal contacts and contacts established through previous research work.

Our final list of schools included the following, with anonymous names.

City School: an all-age primary school (360 children) in a deprived inner London area;

County School: a junior school (550 children) in a well-to-do town within commuting distance of London;

North School: a junior school (370 children) in an area of high unemployment near a northern industrial town;

Infant School: an infant school (150 children) in a rural area between two villages on the outskirts of the same northern industrial town;

Town School: an all-age primary school (350 children) situated on a housing estate near a small town in the Midlands;

Village School: an all-age primary school (104 children) in a wealthy village in the Midlands.

Some fairly factual details about the schools are set out in Table 2.1.

Methods

The case-study work was carried out in 1994 over a period of about a month in each school, at the rate of two to three days a week. The researcher spent time as a general helper in a class where children were aged 6–7 years (usually called Year 2) and in a class with 10–11-year-olds (Year 6 or top class) and kept fieldnotes on events in the school day. She filled in a checklist of health-related topics, which amplified the questions we sought to address in the questionnaire.

The researcher interviewed the headteacher, using the survey questionnaire and a checklist as a basis for discussion. She interviewed the class teachers for the Year 2 and Year 6 classes, and any teacher responsible for health education and/or PSE, and also interviewed other staff whose work was relevant to our enquiry, including: secretarial and administrative staff; supervisors

Table 2.1 The case-study schools compared

	Case-study schools					
	City	*County*	*North*	*Infant*	*Town*	*Village*
Age-range	5–11	7–11	7–11	5–7	5–11	5–11
Nursery class	✓	×	×	✓	playgroup	×
Area	Inner-city London	County town, nr London	Small town, North	Rural nr indust town, North	Estate near town, Midlands	Village, Midlands
Main catchment area	1 mile	2 miles	½ mile	1 mile	½ mile	1 mile
Building (basic)	1870–90 4 storey	1960s 1 storey	1920s 1 storey	1970s 1 storey	1960s 1 storey	18th century 1 storey
Outside space						
sports court	×	✓	×	×	✓	✓
field	×	✓	✓	✓	✓	×
ad playgrd	✓	✓	×	×	✓	✓
quiet area	×	✓	×	×	✓	×
garden	×	✓	✓	✓	×	✓
No. of children	360	550	370	150	350	104
All staff	41	41	43	18	34	11
Ratio staff–ch'n	8.8	13.4	8.6	8.3	10.0	9.45
School dinners	✓	✓	✓	✓	✓	no
Caterer	LEA	Catering firm	LEA	LEA	LEA	packed lunch
Where cooked	premises	premises	premises	sent in	premises	
% ch'n free dinners	60	8	33	29	17	9
First-aid room	secretary's office	entrance area	Secretary's office	entrance area	secretary's office/staff room	classroom/library
SHS room	sole use	entrance area	resources room	entrance area	hall/office	library/hall
Nurse visits	1/week	4/term	1/week	1/week	3–4/term	4/term

and dinner ladies; the school nurse. In practice, six to eight staff were interviewed in each school: in all twenty-one teachers, fifteen non-teaching staff and eight staff providing specific services (forty-four altogether). (Full details of people interviewed are given in Appendix 4, Table A4.1, p. 252.)

For staff interviews, we used a topic list and encouraged staff to develop points and introduce their own agenda in an informal discussion. Topics discussed included: staff remits and responsibilities; dealing with illness and accident; issues concerning children who needed special care; health education

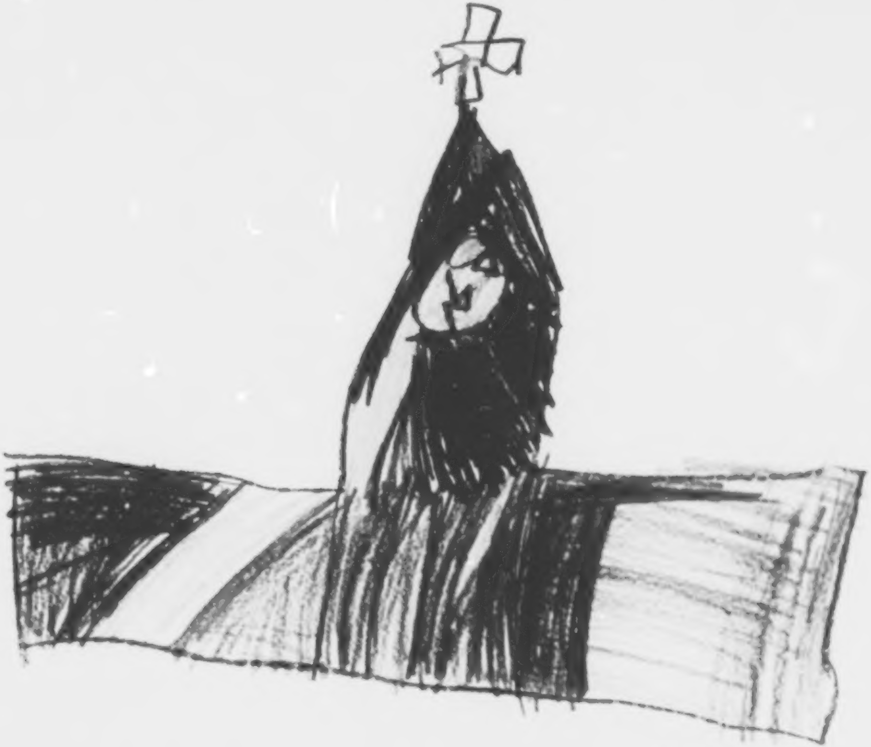

Plate 1. The school building

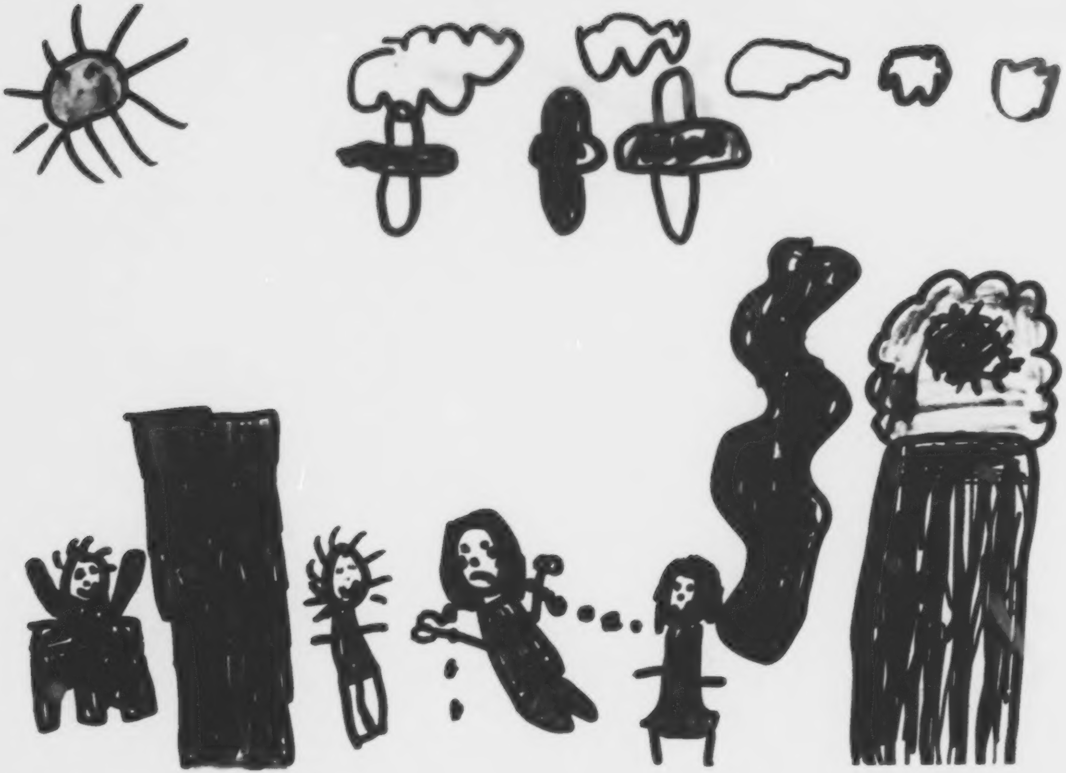

Plate 3. An accident

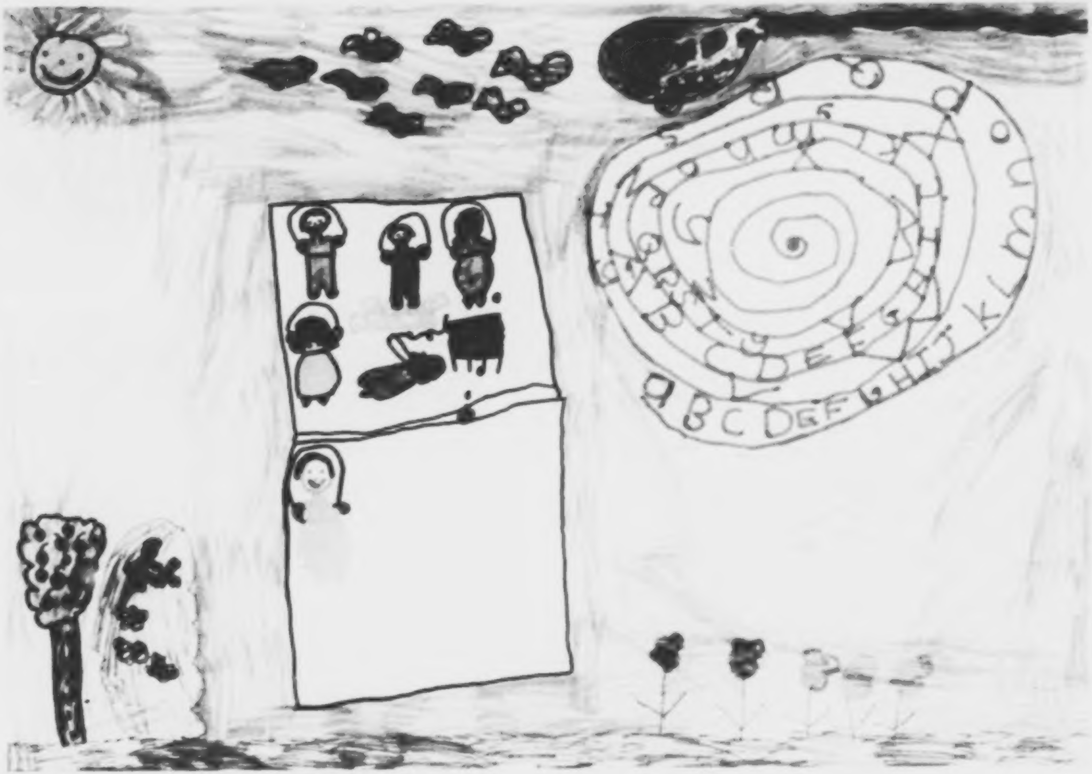

Plate 4. The playground

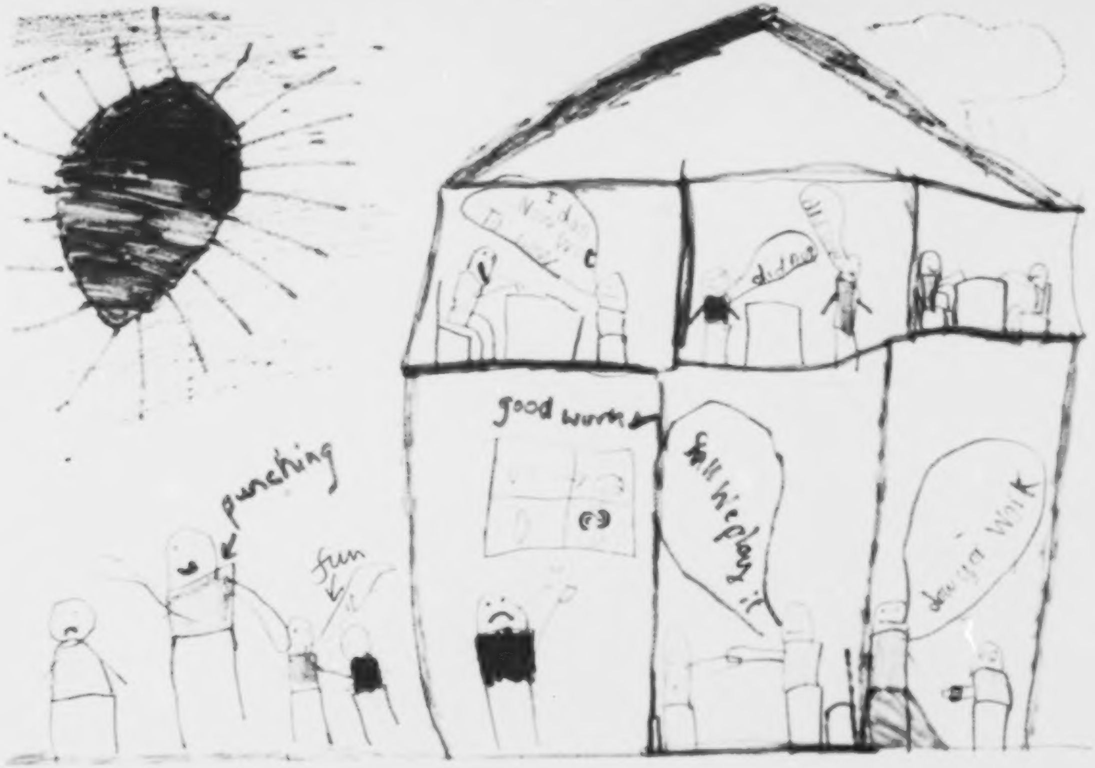
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Plate 5: The school day

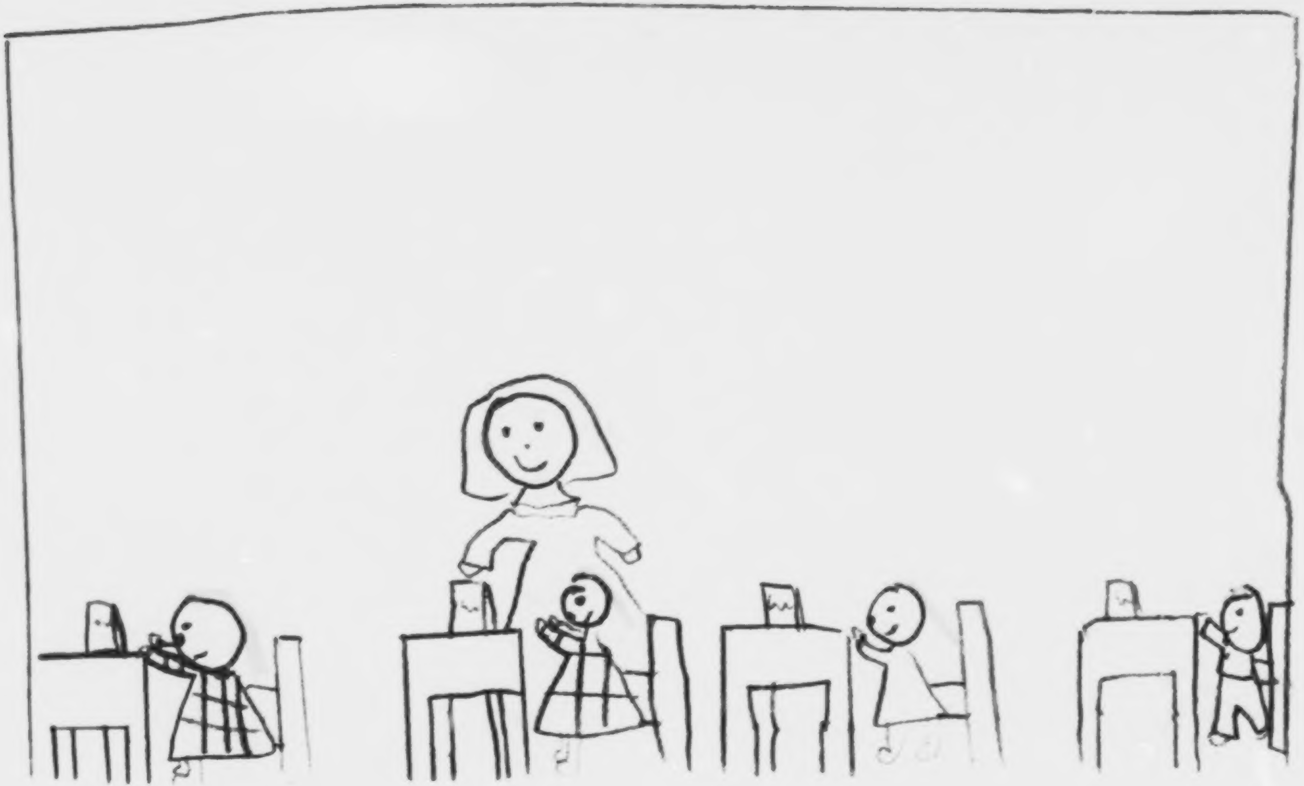

Plate 7: Me at school

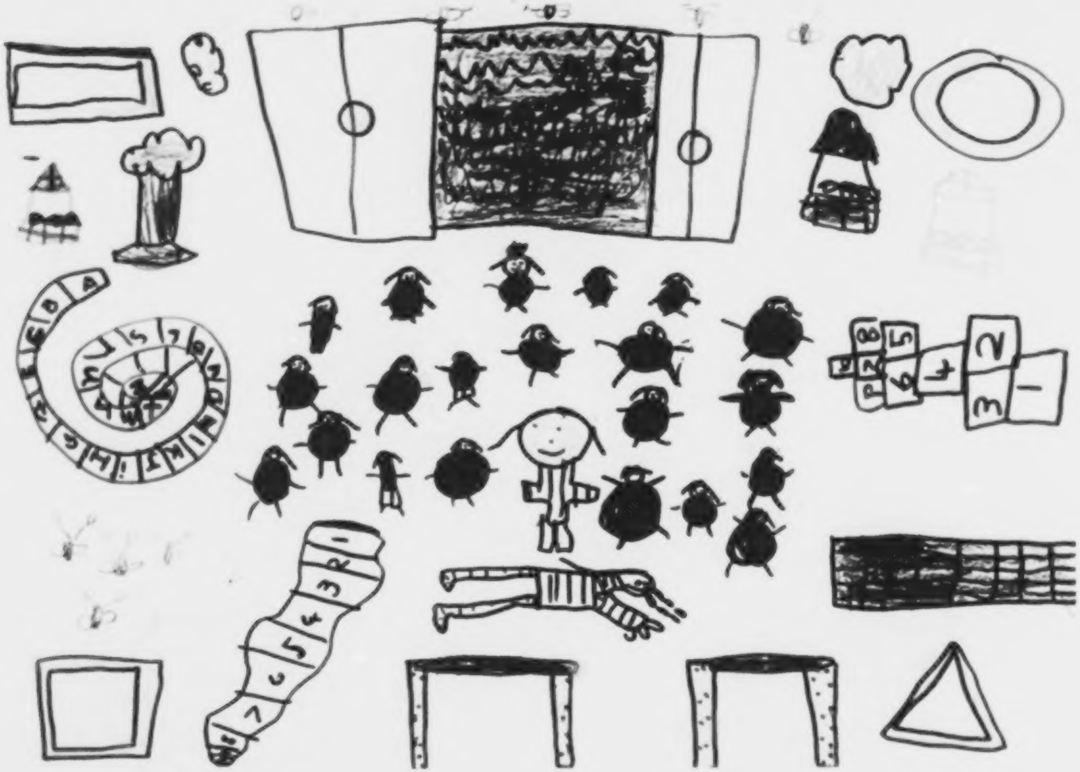

Plate 8. An accident in the playground

promotion policies and practices; the contribution of the school health service; the quality of the buildings and playspace; the school as a health-related environment for children.

A major feature of the case-studies was the children's own accounts and views. Once the researcher had established some familiarity and acceptance with the children, she negotiated agreement from them to participate in the study. (Data collection will be considered in more detail in 'The View from the Children' pp. 175–6.) She collected data through a range of methods; these were standard across the schools, but modified in the light of particular circumstances. The main methods used were group interviews, topic work, drawings and essay writing.

As Table A4.3 (see Appendix 4, p. 257) shows, our sample of 264 children included ten classes, with two each at City, County, Town and Village and one each at Infant and North Schools. Interviews with the children were carried out with pairs of children, occasionally threes, where convenient. The aim was to reduce the power imbalance between adult and children, and to enable children to discuss issues with each other. The pairs were self-selected in most cases, although availability to be interviewed depended also on work commitments and teachers' views. Where possible, the researcher took the children out of the classroom to a quiet spot (library, corridor, sick room). Almost all the interviews were taped and transcribed, but in a few cases taping was not possible (because of local noise levels), and in all cases the researcher kept notes of the interview. Each interview has been treated for analysis purposes as providing one set of data. That is, we have recorded whether or not a topic was mentioned in an interview, rather than how many children mentioned it. This is because, as noted, our method encouraged children to raise and discuss points with each other, and the data therefore comprises interview points rather than individual points.

In the interviews, the themes explored with the children were: the best and worst things about school; the best and worst places and times at school; their experience of illness and accident episodes; school now compared to when younger; whether and why they would attend school if it were not compulsory. In addition, the children were asked to write brief notes on certain topics: what keeps you healthy? Where does health care take place? Whose job is it to keep you healthy? and, What healthy and unhealthy things do you do at school? Finally, some of the children, depending on the amount of time and willingness they had, drew pictures on one or more of the following: me at school; the playground; school dinner; an accident; a healthy and unhealthy person.

The third set of people whose views on the school would be useful was parents. We aimed to collect data through a questionnaire to parents of children in the classes studied, and through group or individual interviews held at school at a time to suit them. This enterprise was less successful than the others, since we did not have enough time to establish good working relationships with parents. The questionnaire was either sent by post or sent home with a child, depending on the school's view of the best method; overall we had a 33 per cent response rate (eighty-nine of 267 sent) with variation between schools from 11 per cent to 50 per cent, and a generally higher response rate from parents of younger than of older children (see Table A4.2, p. 253). We also sent out requests to parents to come to a discussion group, or to grant individual interviews. Again, take-up was low. Almost all who accepted were mothers. Given these low response rates, we have used the data simply to give glimpses of parental views.

During the summer term 1995, the research team made a return visit to each of the six schools to check our data and discuss issues further. In September 1995, we sent each case-study headteacher a draft of the chapter for comments, and amended the draft accordingly. We also asked them to list changes in numbers of children and staff for 1995–6 and to outline their major priorities for the coming year.

Some Comments on the Case-studies

We attempted both to adopt a standard set of data collection methods across the six schools, and also to take account of the individuality of schools, the researcher and the children. We used standard lists of interview themes and questions for topic work, and the research team maintained regular contact during the fieldwork, with regular project meetings to discuss issues arising, and to make sure methods remained both constant and flexible. Each school was individual, as we hope to show and this meant that it was appropriate to interview a slightly different cast of adults in each. At North we interviewed the education welfare officer based in the school, whereas at County the welfare assistant employed to care for ill children was interviewed. The two researchers had each their own distinctive style and character of interaction with the adults and children at the different schools, and will have stamped the data accordingly. The children varied, too, in their chattiness and confidence and in some cases the researcher spent more time establishing a comfortable atmosphere for the interview. There were other issues. For instance, at City School, where many of the younger children spoke little English, children needed extra encouragement to talk, and could not all write about their experiences and views. With these and some of the other younger children, it was especially useful to encourage them to draw pictures of aspects of school life, such as the playground and dinner time.

We should note too that the data collection took place in two phases with the school summer holidays intervening. This period allowed us to reflect on the fieldwork so far and caused us to make a few additions to the topics raised. In particular, in the last three schools (Infant, Town, Village), we asked children what health education topics they had done, and what experience they had had of the school health service.

Finally here, we should explain what the case-study chapters comprise.

We have used fieldnotes and factual data to provide an account of the school, which is therefore a blend of researcher's observation (e.g., was the playground spacious?) and information collected from staff, especially the head (number of children, frequency of nurse visits, helpfulness of LEA, and policy on health education). We have provided a sketch map of each school, mainly to show the spatial relationship of buildings to outside space — and its facilities. The chapters also include the staff's views on the topics we raised with them, and we have presented these anonymously (in response to some staff concerns about being identified). We have reported briefly in each chapter on parents' and children's views on the topics reported — and children's perspectives are considered in more detail in 'The View from the Children' pp. 173–201. Each chapter ends with a discussion — our thoughts on the data collected.

Each of the chapters follows the same format, so that the reader may compare data across schools. The arrangement is as follows:

Introduction: The School and Its Environment
The School as a Health-care System
  School Buildings and Playspace
  Health Maintenance: Exercise
  Health Care: Accidents and Illness
  Health Maintenance: Food
  Health Education and Health Promotion
  The School Health Service
Discussion
  Provision and Intervention
  Divisions of Labour
  School–Community Relationships
  Understandings of Children at Home and School
  The Status of Children's Health at School

City School

Introduction: The School and Its Environment

City School was a maintained primary school with an attached nursery class, situated in an inner London borough in an area with a varied social and ethnic composition. The borough itself is one of the most deprived in London and, according to the headteacher, the school's catchment area is one of the two most deprived in the borough. An indication of family poverty is that 60 per cent of the children had free school dinners.

The school was sited to one side of a main road out of London, in a residential area, mixed in type: Victorian terraced housing, some converted into flats by housing associations; council flats; and private town houses. Immediately behind the school was a dusty building site where more town houses were replacing a derelict light industrial complex; the noise from construction work interrupted school activities.

Most children walked to school, with some coming by car or bus. There were several small shops within easy reach and a high street with supermarkets and smaller shops was about ten minutes' walk away. The nearest hospital and the community health centre, with mother and child services, were each about a ten minute walk away, or five minutes by car.

This school had 360 children (like 10 per cent of survey schools) and staffing was generous, as confirmed by the headteacher. Staff–child ratios were 8.8 (similar to North and Infant). Given that many children (usually about 250) had a mother tongue other than English, the school had three teachers funded through Section 11 funding and a Turkish language support teacher. However, the Section 11 staffing had been reduced in 1993–94 by half to 1.5 teachers. In all, there were thirteen class teachers, three special needs workers, six other teachers, three administrative secretarial staff, fourteen non-teaching assistants and a caretaker. Each infant class had a class helper for a day a week, and the junior classes for half a day. The headteacher, deputy headteacher, and several other class teachers were male. Staff varied in age and ethnicity. Turnover of staff meant there were several supply teachers, from Australasia. By our return visit, the school had 400 children (summer 1995) and by September 1995 numbers were up to 435, but the school building was large enough to cope with this. In September 1995, the school had gained two special needs helpers funded by the LEA.

Class sizes were smaller at the top end of the school, and all classes had fewer than thirty children. The children came from a wide range of ethnic

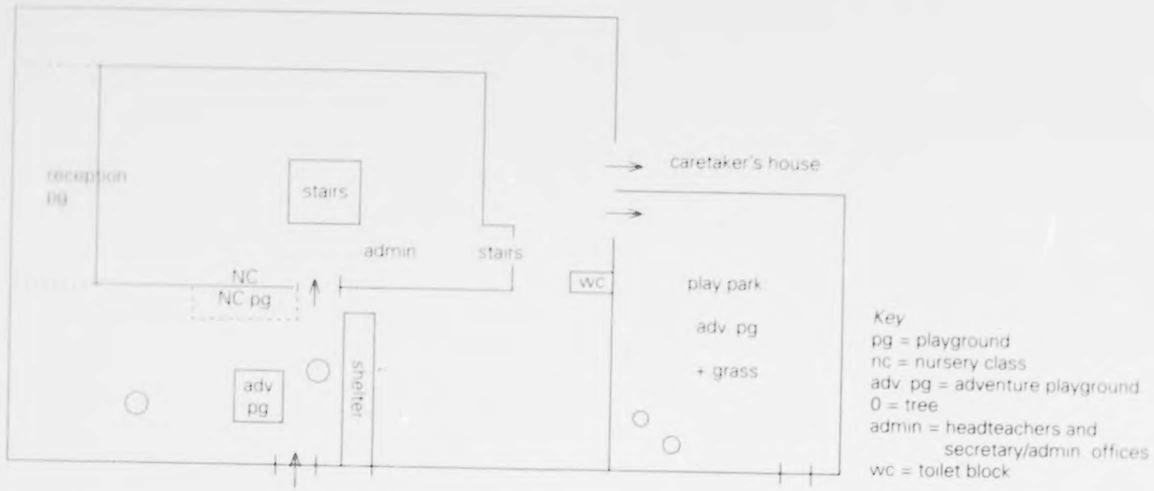

Figure 2.1 *Sketch map of City School*

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backgrounds, with a minority from white indigenous backgrounds. The school had many refugee children (notably from Kurdistan and Eritrea), who usually required extra input since their first language was not English; some had health problems that health services had not resolved; one teacher described these children as 'both physically and emotionally very unhealthy'. The headteacher explained that these children tended to stay on, even if the family moved house; according to the school nurse, this school had higher proportions of refugee children than the other (four) schools on her list.

The researcher's impression was of a lively and friendly school environment, with an informal atmosphere. One indication of this was that staff were on first name terms with the children.

The School as a Health-care System

School Buildings and Playspace

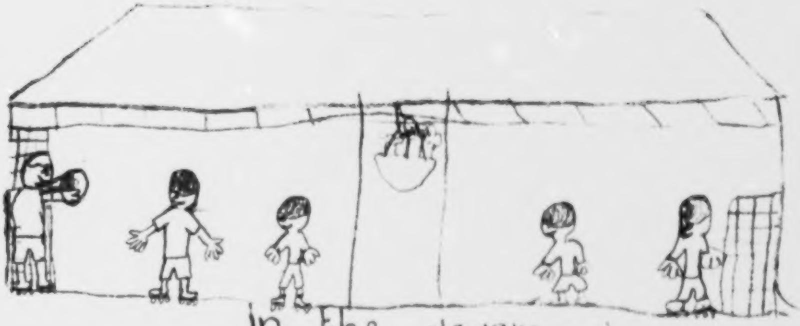
The main building (like 22 per cent of inner-city schools) was a four-storey Victorian brick structure, with some more modern additions, notably a downstairs annexe for the nursery class and a second staircase block to supplement the original central stone staircase and act as a fire escape. An old prefabricated building, designated as a Parents' Centre, took up some playground space, but was closed because of asbestos; it was demolished by the time of our return visit. The only entrance to the school was through a gate in a twenty-foot wire fence. The main door had been fitted during the last year with lock, security door code pad and answer phone; in practice during the data-collection period this door was often left open to let in light and air. All the downstairs windows of the school were covered with grilles.

The entrance hall was overlooked by a large pleasant administrative office. The headteacher commonly worked there, but had his office on the half-landing above the ground floor. Spiral stone stairs wound up with full- and half-landings and on each of the three main levels there was a large echoing hall. Classrooms opened off these halls, with windows onto the halls as well as to the outside. The staffroom and classrooms seemed roomy and in fair decorative order. Unlike most primary schools, this one had a small medical room, not shared with any other function. However this room was on the third floor and in practice most first-aid was carried out in the administrative office. Going down to see staff there was a common activity; children went there if they were naughty, ill or distressed, and following accidents.

The halls were used for PE, playtime on wet days, and for dinners. Whole school assemblies once a week and age-group assemblies daily also took place here. Cloakrooms with toilets were on each floor and there were also toilet blocks outside in the playground.

The playground space was on all four sides of the school, and was small

Tuesday 5th July



in the playground

I like playing with my friends

scored
football in the Shed and I Sod

goal
One good and my friends

scored goals
Sod ten good and my friend

won the wold cup and I feel
happy

Figure 2.2 In the playground: 'I like playing with my friend's football in the shed and I scored one goal and my friends scored ten goals and my friends won the world cup and I feel happy.'

for the number of children. It was asphalted except for a few square feet around several tall plane trees. The infant and junior playground were divided structurally by ancient shelters and a brick wall, and more informally by metal barriers to demarcate playspace for different age-groups. In the infant playground there was one modern play structure with a safety surface. Adjoining the school, but outside its boundaries, was a play park: a spacious adventure playground with a grassed area, owned by the local authority but used only by the school during playtime, by year-groups on a rota. It constituted a positive addition to the playspace, and children identified it as a favourite place at school. The school was negotiating with the council to take over ownership of this space. One of the main projects for 1995–96 was to landscape the grounds, provide new fencing and establish a garden, paid for from the school's budget.

As in all schools, many younger and older children regarded playtime as dangerous; bullying, including racist behaviour and aggressive play, were features. They identified the cramped playspace together with football play as major factors. Younger children especially expressed fear and caution about playtime, and some preferred the safety of the classroom, and (in two thirds of interviews) recalled the protected environment of the nursery class as preferable.

The headteacher and secretary rated the building itself as very good; it was structurally sound and spacious, with many rooms. The head rated input from the LEA very poor: it was currently able to fund only the most urgent repairs. For the school, priorities included: repairs to the outside toilets, painting the building, replacing the boilers. Staff views differed on the playspace: those who made comparisons with non-city schools emphasized the restricted space and lack of grass and playing fields, whereas others accepted these limitations and emphasized the recent improvements made. These included: segregating children by age, limiting football games to one area, making planted areas, teaching children games.

Among the six mothers interviewed, there was general acceptance of the physical environment of the school, with appreciation of the grassed area, but some comments on the desirability of more playspace. Few parents who returned the questionnaire (nineteen of forty-seven or 40 per cent) commented adversely on the building (three) and outside space (four). It seems likely that the generally favourable comments resulted not only from positive aspects of the physical environment, but from several recent improvements.

Health Maintenance: Exercise

The school day provided a morning break for all children and an afternoon break for the infants (15 minutes); and a dinner break (75 minutes). At playtimes children were segregated by age-group. In the limited space, demarcation

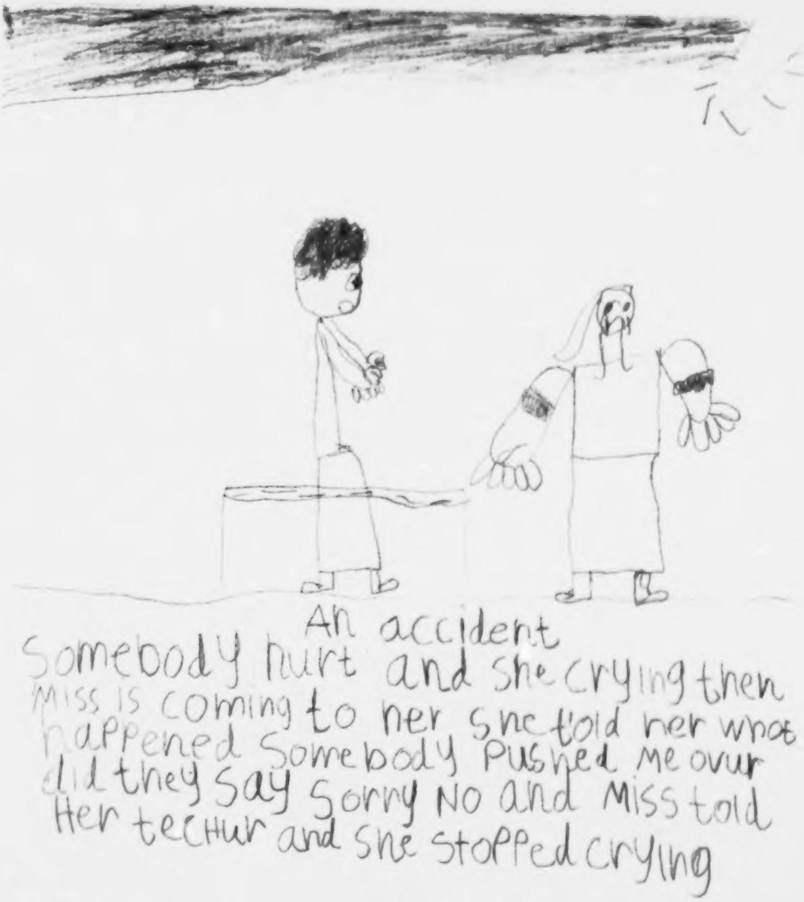

An accident
Somebody hurt and she crying then
Miss is coming to her she told her what
happened Somebody Pushed me ovur
did they say sorry No and Miss told
Her techur and she stopped crying

Figure 2.3 An accident 'Somebody that hurt and she crying, then Miss is coming to her. She told her what happened, "Somebody pushed me over." "Did they say sorry?" "No," and Miss told her teacher and she stopped crying'

disputes arose frequently, and accidents were frequent. Teachers supervised at breaktimes but not at dinnertime. There seemed to be ample supervision (twelve adults at one count at dinnertime), some good humoured but with some angry episodes. According to several staff, a joint decision had been taken to try to improve children's experience in the playground, through providing them with play equipment and through initiating games. The researcher observed some organization by adults of skipping games and other games in the infant playground. The reception class children had been provided with a separate playspace. The junior playground (the other side of a gate) was more open and sunny and was marked for ball games, but dominated by football.

Exercise had a high profile in this school, spear-headed by senior staff, some of whom had physical exercise training. A senior teacher had been appointed to coordinate the PE curriculum, and was also responsible for PSHE (Personal, Social and Health Education). At the time of fieldwork she was writing school policies for these. The headteacher said he had initiated this work because the school needed a cross-school policy and the children's needs for physical exercise and PSHE education were great. One teacher argued that health education should be taught through physical education — an approach developed in Australasia (cf. Kirk and Tinning, 1994), and introduced to the school by a teacher from New Zealand. 'Fit, healthy children learn better,' so the usual order of events — activity as reward for 'school work' — should be reversed: 'Do your PE well and then you can do your sums — that's the way it should go.'

The younger class had two PE sessions a week, in total 1.5 hours, doing dance, gym and games, but did not go swimming. In addition, on Friday afternoons they had a 'choosing session' and often chose physical activities, with games equipment. The older class did PE every day and also went swimming, taken by hired coach to a local secondary school. Opting for this training pool rather than for the local play-pool was regarded as important, though expensive in time and money. There were also dinnertime gym and skipping sessions; after school sports, such as rounders, cricket, touch rugby and football, organized by the PE teacher; and dance and gym clubs (paid for by parents).

Mothers seemed to approve of the high level of PE in the top class, but otherwise did not comment much on physical activity as a feature of their children's day. However, the older children enthusiastically endorsed PE and its link with good health.

Health Care: Accidents and Illness

There was no first-aid room, but first-aid boxes were kept in the nursery and reception classes. The main first-aid site was the spacious administrative office; the children had easy access to the room through its ever-open door. Two non-teaching staff and the secretaries had done some first-aid training. The secretaries and supervisors dealt with most of the minor illnesses and accidents. More serious ones were referred to one of the senior teachers who had some medical training.

The school recorded all accidents that came to staff attention, and illness incidents, and this efficiency may mean we acquired a false impression of high incidence. Though it is impossible to compare the numbers of accidents and illnesses in our six schools (because recording systems differed), we heard about more, and more serious ones, at this school than at others, and also observed streams of children coming for help to the administrative room. During the fieldwork period (half a term) sixty-seven accidents were entered into the accident book, of which three-quarters took place in the playground. A quarter of these accidents happened in the context of arguments and/or fights. There were three hospital referrals during the fieldwork for accidents — this high usage may have resulted in part from its nearness to the school. Thirty children were sent home, of whom about a third had accident-related conditions. The medically trained teacher described several serious incidents, arguing that schools should have properly trained staff. A supervisor reported frequent fights, especially among the younger children, and said some 'accidents' resulted from fights — the researcher observed many of these. Perhaps the most important factor accounting for numbers of accidents was the restricted playspace, mostly with hard surfaces.

The school kept a computerized record of parents and a back-up contact, and staff noted that almost always they could contact someone to come and resume responsibility for children. School policy was to refer children back to parents in case of accident or illness. As a senior teacher said: 'The tendency is to offload all the responsibility onto their mothers as quickly as possible.' This was confirmed by the secretary and head; they contacted parents at an early stage. Mothers agreed that they should be called to come to the school, although some of their stories focused on problems with the division of labour. For instance, one mother said she resented being called 'for nothing', one had not been informed about her child's accident, another disagreed that her child was ill and needed to be taken home.

This school had its share of children with asthma, sight and hearing and learning difficulties, but staff pointed also to high incidence of infectious or contagious conditions such as ringworm, lice, threadworms, gastro-enteritis; these sometimes infected a whole class of children. The school health service was thought to be offering insufficient input to deal with these public health issues:

> It's not quite as bad as Victorian times, but these children need more screening than they're getting. It would be nice [sarcastically] if — you often see a child with a blemish or blotch — it might be the start of ringworm. It would be rather nice if a nurse was actually available.

The children generally understood the division of labour in care, although some of the younger ones found the journey to and from the administrative room confusing — they got lost initially. Most of the younger children, as generally in our schools, thought they got good care. Older ones distinguished between good care for serious matters and dismissive adult behaviour for more minor ones. Some experienced sitting in the administrative office as neglect, in spite of staff presence and help.

Health Maintenance: Food

School dinners were provided by the LEA, and cooked on the premises. Staff thought almost all the children stayed at school for dinner; 60 per cent had free school dinners, much the highest proportion among our six schools. A small group of older children brought packed lunches, and the school banned sweets, canned drinks and crisps from these. The school provided milk free to the nursery class, funded by the LEA, and milk was provided with the school dinner.

The cook put up the day's menu in the front hall. She discussed meals with the supervisors and the head. Children took part in discussion of menus at Christmas and during projects. Teaching staff praised the cook for her work in trying to provide a balance of healthy and popular foods, and in going beyond her remit in doing her best with the available resources.

Infants had their dinners in the ground floor hall, and juniors in the second floor hall. The infant class teachers took the children to the hall, helped them choose, and settled them at the tables; they then went away. The headteacher sat with the children. Apart from this, supervisors monitored dinnertime. As younger children noted, dinnertime was noisy, perhaps partly because of large numbers in echoing halls. In 1995–96, two sittings for both infants and juniors had been introduced, and dinnertime was consequently more relaxed and quieter.

Four of the six mothers interviewed commented adversely: noting there was sometimes not enough food, poor quality food or not enough choice. A third of those returning the questionnaire (six of nineteen) also commented adversely. There could be several factors here: high proportions of the children had school dinners; poorer parents who paid for dinners might expect, as purchasers, a good dinner; and parents would probably think of the free school dinners as important constituents of children's diet.

As at North School, where the cook was similarly pro-active and staff were also actively interested in the dinners, many children, especially the younger ones, praised the dinners: 'I like the food, it's nice food. I like fruit as well, and apples.' However, some older ones said there was not enough food, and not enough choice. Given the range of ethnically related diets, the school had difficulties providing enough of all choices.

Health Education and Health Promotion

A senior member of staff had been appointed in 1994 (spring term) as coordinator to develop policies and improve practice. She argued for a whole school approach, and an integration of physical education, health education and PSHE. The policies were being developed at the time of fieldwork and a PSHE policy document was prepared by March 1995. The planned curricular education programme covered safety, family life, substance use and misuse, sex education, personal hygiene, psychological aspects of health education, and nutrition.

At the time of fieldwork, the emerging policy could be seen in action in the school–parent–child charter, which emphasized good behaviour, responsibilities and duties of staff, parents and children. Given the complexity of links between health education, PSE and PE, staff held differing views on how best to promote children's health. We noted earlier the view that health education should be taught through PE; some staff emphasized promoting the psychological health of the children. It was planned to give each child a PSHE book to accompany the child through the school years, recording topics covered.

During the academic year 1994–95, sex education had been dropped because of media publicity surrounding a school nurse (elsewhere) accused of inappropriate sex education sessions. Older girls were particularly appreciative of these sessions and thought there should be more of them, in spite of the boys' behaviour:

> *Girl 1*: We learn a lot, but not enough in some ways, about periods and the body and so on.
> *Girl 2*: Some of the boys don't want to know.

Parents approved of health education taking place at school, but generally argued that the main input took place at home. Interestingly, one mother said it was her job to inspect the toilets to make sure they were fit for her son to use. Both the questionnaire and the interviews indicated parental concern for good hygiene practices at school: the school should make sure facilities were clean and children should be encouraged to keep clean — as the teacher of the younger children agreed.

The School Health Service

This was the only case-study school to have a designated SHS room. The school nurse, associated with the school for many years, came for one session a week, the doctor twice a term and the dentist once a year. The nurse had five schools on her caseload, among which this one, she said, was one of the most needy. Turnover of doctors was high: two changes in the last three years. The SHS offered whole class surveillance at reception class level and again in Year 6. In addition, children had health interviews during their school career at age 8 and consultations on request. Hearing and sight were tested twice during this period. Incomers to the school were checked by the nurse or by the doctor if newly immigrant. There were formal liaison systems for communication between the SHS and the head. The nurse took responsibility for arranging the medicals, sending letters out to parents and asking them to complete a medical history questionnaire. The secretary (compared to many schools) said she played a minor part and 'did not get much involved in that side (of school life)'; she took messages, and collected returned notes on parental attendance. However, when teachers spotted a medical problem they tended to ask her to arrange a medical check.

The headteacher rated the service poor on quantity — since many children, notably the refugees, had health problems. He rated it average on quality.

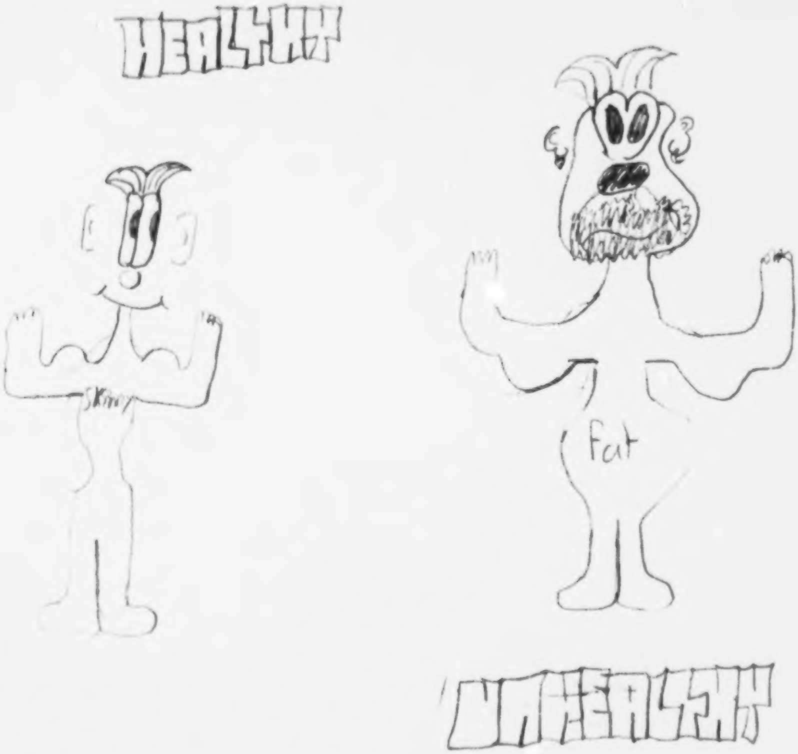


Figure 2.4 Healthy and unhealthy people

He thought there should be medicals bi-annually, the doctor should visit monthly and the nurse for a whole day each week. Some older girls also argued for a help and advice service on site. Other staff commented that the SHS did not help adequately where children had serious conditions; the combination of poor social conditions locally and low SHS input was severely problematic. One senior teacher summarized the major points, also made by others:

> It's not any one person's fault, but there's not enough input. Children need more screening. Children come to school with notifiable diseases, which are not followed up — e.g., ringworm and headlice. Before they build up resistance, diseases spread; sometimes half the class is laid up with gastro-enteritis. The system doesn't allow the school nurse to be approachable. The SHS doesn't follow through chronic or serious problems, for instance acute heart conditions. There's no counselling. [He argued that same sex counselling was needed especially for some of the more mature, older girls.]

In sum, the public health and individual health-care system required at school for children living in a highly disadvantaged area was not in place.

The SHS input provoked conflicting views among staff. This seems to be because, whilst some good work was done, there were many children with health problems and inadequate input to deal with them. Both the headteacher and the nurse reported that child abuse cases took up a lot of SHS time and distracted attention from straightforward physical problems.

Among the six parents interviewed, five reported failings: a cursory service, poor information, poor quantity of input. As in all schools, mothers bitterly regretted the withdrawal of SHS work on infestations (see Discussion Section, p. 216). This mother, replying to the parent questionnaire, summed up many parental complaints and common viewpoints.

> I'd like to know it exists: what its functions are and how it operates. One is not aware of it. Contacts between the SHS and parents are virtually non-existent. I have not had any health report this year and I have never seen the school doctor. I feel the nurse and doctor should be available at all times. Parents should be notified of any medical test (teeth, eyesight), even weight and measurement results should be communicated. Last year I had to insist on a repeat eyesight test because I knew she had problems when I was told she had not. (Mother of 6-year-old)

Discussion

Provision and Intervention

The school had an old building but it was spacious and adaptable to varying uses and demands, and was in good condition, apart from the outside lavatories. There was a wide, light entrance hall, with a spacious administrative room overlooking it. It had a restricted playground space, almost all hard ground. The children came from a deprived socio-economic area of the borough, and included many immigrants and refugees.

The school had intervened to improve the physical environment in many ways. The entrance hall had been modified to provide a more welcoming and also secure approach to the school; it had many notices and displays, including the charter and photos of staff. The large, high spaces were hung with children's work. The school had worked on the playground by painting the walls, putting up play structures with safety surfaces, dividing the playground by age, and building small, planted areas round the trees. The adjacent play park was an appreciated addition. Plans for 1995–96 included an environmental garden, increased nursery class provision (numbers and hours), and a parents' room.

Within its large building, the school was able to provide rooms for art, music, computers, an infant and junior library and a special needs room (but this would be used as a classroom from September 1995). High levels of resources based on the capitation system, in conjunction with LMS, had enabled the staff to implement many of the improvements noted above.

This school had taken steps to develop policies aimed at strengthening the children psychologically and physically. Apart from the PSHE policy, a number of initiatives had been started: class awards for good work; and listing of children's achievements in the weekly school newsletter. The promotion of healthy bodies through plenty of exercise was seen by some staff as promoting better work, and thence self-esteem. Initiatives to improve children's behaviour and happiness at playtime included: restricting football to one part of the playground at dinnertime only; providing equipment for children to take out at playtime; and teaching the children games.

Divisions of Labour

In this large school, in contrast to the much smaller Infant and Village schools, there was a fairly clear division of labour between teaching and non-teaching staff; though teachers dealt with minor health problems in class, non-teaching staff did most of the health-care work. However, the presence of a teacher with some medical training, meant that serious cases were referred back to him.

As to the division of responsibility between the home and the school, staff agreed that parents should be contacted at an early stage. Notably, according to staff, children came to school with serious conditions and with infectious diseases, and they felt justified therefore in referring the children back home. The input from the school health staff was insufficient in quantity to help substantially with these problems. As one teacher said:

> It's not uncommon for children to be sent to school with serious pains and illness. The most recent occasion was a girl with a sharp pain in her stomach, on the right side for appendix — we called the parents immediately. If children say they felt like this when they left home, then it's straight back to the parents: Come and get your child.

The designation of the administrative office as the site of child health-care seemed to relate somewhat to its positioning, character and use. It was near the entrance, large, had open access, had the photocopier and a computer and was used by all the staff, coming in and out. Generally there were two or more staff there, including supervisors, who would bring children in from the playground and use the first-aid box and sink. It seemed to be the hub of the school. The organization of care was informal: no-one was formally designated as the first-aider, but in practice, children were looked after by the secretaries and any available non-teaching staff. The caretaker, who had a house on site, took an active part in a range of school activities, including monitoring children in the playground and in the office and helping with photocopying in the office.

The general office was the main site of the lay health-care system, also for discipline. Again, the physical arrangement of the school may have been relevant. The headteacher's office was somewhat cut off from easy access, and the head spent much of his time being generally around, including working in the administrative office. Whereas at Town School, children generally went to the head's office for disciplinary matters and to the bursar for care, here at City, the boundaries between discipline and care were somewhat blurred. Or to put it another way, distinguishing between treatment for behaviour and treatment for ill health can be seen as an artificial distinction.

School–Community Relationships

This school, based in a deprived area, had difficulties in getting local people in to help out with school activities. A mobile, highly differentiated (by ethnicity, family structure) population, with poverty and stress as common problems, was not a ready-made community and not an easy population to relate to.

The school had put in place several initiatives to encourage good relations between home and school. The school celebrated a number of diverse religious festivals in assemblies. It was working towards an action plan on equal opportunities, within which racism and gender issues were prominent. When children joined the school, parents, teachers and children (juniors but not infants) were asked to sign a contract listing each party's contribution to children's welfare and achievements. The school had started a homework scheme, which asked parents to work with their children on a project and assess its value and their enjoyment of it. By the time of our return visit, a staff photo display was up in the entrance area, which no doubt helped parents identify staff. There was a regular drop-in meeting for parents at the school each week; and there had been a meeting to discuss establishing a parent–staff association — with the emphasis on including all types of staff, not just the teachers. The school issued a regular newsletter to parents with information about events to come and about the children's achievements. In 1995, the school had instituted Bengali and Turkish parents' groups, meeting weekly, to encourage these ethnic minority parents to participate in school life.

Some parents had been pro-active: there was a PTA and a group of parents had set up a regular bookshop-cum-meeting but, according to the headteacher, this initiative suffered from lack of interest, and language differences were a problem. Other input from the locality included higher education students on placements arranged through Community Service Volunteers. In the previous year, the school had had help with health education teaching from the police, the fire brigade and British Rail (on safety issues in connection with the nearby railway). The PSE coordinator was planning further input from the Sports Council, the LEA physical education person and the school nurse.

Understandings of Children at Home and School

There was evidence that the children were regarded as competent actors in working with adults to construct the social order of the school. For instance, they had been active in drawing up the charter between school and home; and had taken part in planning the play park and the design for a large mural painted on a side wall. They served as class representatives on the School Council (established in 1993–94); and were participating in setting up and working on the school environmental garden. Staff interviews were notable for the few negative comments about the children's home backgrounds. It seemed that the school emphasized building on families' and children's strengths rather than identifying stumbling blocks.

The school had a positive programme of policies to reward good conduct and achievement and to publicize awards. These included a weekly award in each class for good work, publicized in the weekly newsletter for families. The headteacher noted that he aimed to raise children's self-esteem through such recognition of achievement, and one of the aims of the PSHE policy was to develop positive attitudes in the children to themselves, their peers and the local community. In the top class, a strenuous programme of physical education (every day) had the aim of increasing the children's psychological as well as physical strength.

The Status of Children's Health at School

This school was concerned about children's health status, given family poverty and other adverse social circumstances. Staff were keen to improve children's health, through physical education, raising self-esteem and giving children the opportunity to participate in measures to improve the social and physical environment. Staff aimed to improve the children's playground experience through provision of play equipment and teaching the children games. At this school (as at North) there was a commitment to the school dinner; a feeling that it constituted an important part of children's nutrition and social experience.

In these senses staff were adopting a whole school health promotion policy. But many children had poor health, and this was not matched by the input from the school health service. Whilst it may be appropriate to reduce the school health service input in areas where children's health is generally good, staff here argued a clear case for more and better input. Dealing with serious accidents and conditions was manageable only because of the fortuitous advantages of having a teacher with medical training — and the hospital close by. And whilst the building seemed to be serving the children well, and the play park was contributing to their opportunities for healthy activity, the main playground was not conducive to health — more to accidents. A third problem was that the numbers of children requiring special help — for linguistic and other problems or conditions — was not matched by numbers of staff. For instance, Section 11 staff-time had been halved in recent months. The great efforts by the school were offset by the physical environment, inadequate staff levels and a poor health service.

County School

Introduction: The School and Its Environment

County School was a maintained junior school, sited in a well-to-do 'stockbroker' town in the commuter belt south of London. It was in a mainly residential area, with large expensive houses with driveways and gardens, and little traffic. Outside the school was a tree-lined avenue, with no pedestrian crossing. There were no shops nearby, the nearest being at least a mile down the road. There was no public transport passing near the school; and, according to teachers, nearly all children were brought to school by car — a large carpark in the grounds was open to parents; one teacher thought its proximity to the youngest class of children (her class) was an accident hazard. The school was about 10 minutes' drive from the nearest Accident and Emergency Department. As an indication of family prosperity, only 8 per cent of the children were eligible for free school meals. Staff said the few poor children stood out among the well-off majority but, more recently, increasing numbers of children from financially hard-up families had joined the school.

There were several private schools for this age-group in the area; and staff indicated that they were in competition with these. Some children had recently been moved to private schools, with class size given as a major reason.

With 550 children, the school was exceptionally large (only 1 per cent of survey schools had over 500 children), and much the largest of our case-study schools. There were twenty classes, five in each year-group, with an average class size of twenty-eight. There were twenty-two teachers, including two deputy heads, two classroom helpers, three special needs support teachers, an administrator, a welfare assistant, two part-time secretaries, nine supervisors and a caretaker. All staff were female except for three male teachers and the caretaker. The headteacher was on extended sick leave. Compared to our other five schools, this one had the highest number of children to staff: 13.4. Like other local schools, this one was under pressure from the LEA to increase numbers: class sizes were due to increase to an average of thirty in 1995–96, with 600 children in all.

The year of our fieldwork (1993–94) was the first year of an important change: from a middle to junior school, so it now took a younger age-band (Year 3: 7-year-olds) and had lost Year 7 (12-year-olds). The researcher thought the school's atmosphere was still suited to its character as a school for older children; it was academic and relatively formal in teaching and learning methods. Bells marked the division of the day into periods. Children wore uniform.

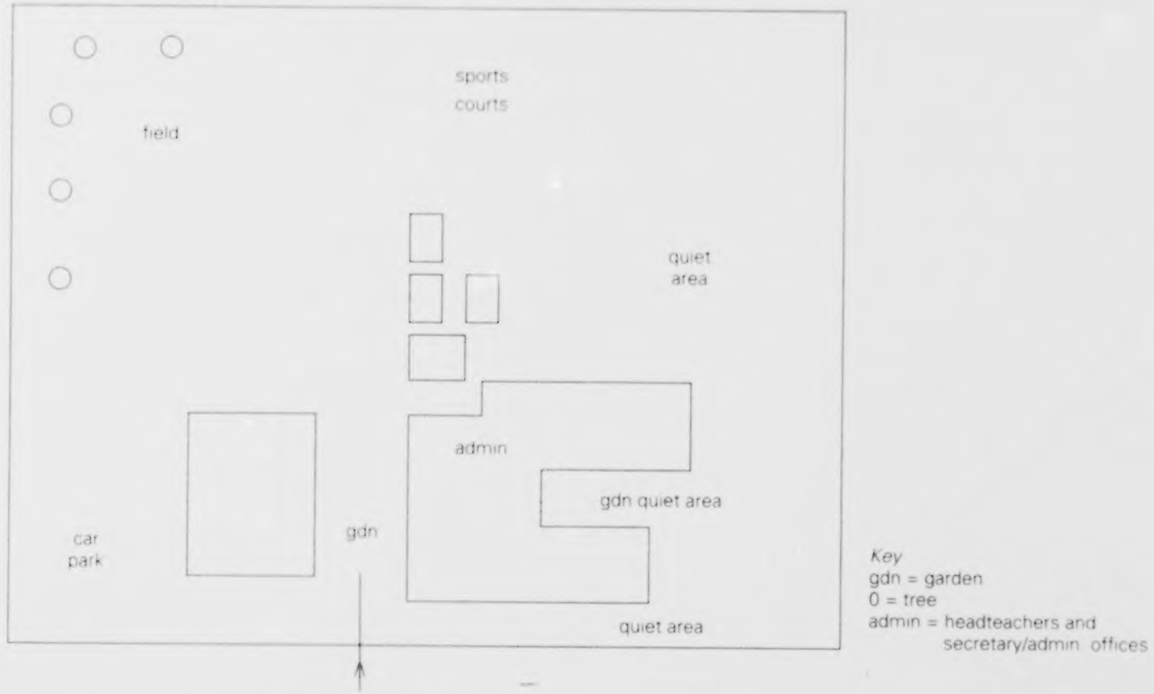


Figure 2.5 Sketch map of County School

However, the perceived needs of younger children for more care had led to the appointment of a welfare assistant to carry out this work.

The School as a Health-care System

School Buildings and Playspace

The main school was built in the 1960s, for a primary school. The entrance hall was an open space, with the headteacher's and administrative staff's offices. These were small and rather cramped. Also in this main entrance was a desk where the welfare officer worked and looked after children. The younger classes (referred to as the lower school), the hall (with gym equipment), kitchens and offices and staffroom were in interconnecting single storey buildings, with toilet blocks between two classrooms. Four of the Year 6 classes were in newer one-storey prefabricated huts. The school was of the same period as Town School, but where Town was designed to meet a specific model of primary school education, this one was composed of industrial modular units, and gave the impression of spaces cobbled together. However, the classrooms were airy, with large windows. There were also several specific-purpose rooms: a library, a studio for art, music and drama, and a French room (all children learned French). The whole area of the buildings, linking corridors and pathways was spacious, and there seemed to be plenty of room for everybody.

Of all our six schools, this one had outstandingly extensive outdoor playspace. There was a playing field area, three hard surface courts, and an adventure playground. The pathway to the main entrance had a range of flower beds and gardens, including a knot garden with a fishpond. There were 'quiet areas' for each year-group, with benches, trees and a flower bed with a particular theme (for instance, a Victorian garden). Apparently in the winter months, playing on the field was limited. As in other schools, use of the adventure playground was supervised and on rota by class. Both these restrictions were a source of bitterness to children, especially the older class interviewed. (By the autumn term 1995 the adventure playground was no longer in use, and 'Trim-trails' — for Juniors and Seniors — had been constructed.)

Staff all agreed that the playspace was very good. However, the building itself looked shabby and drab, with chipped paint and it came in for considerable staff criticism: it was 'old and dirty', 'appalling' and 'disgusting'. We heard that this 1960s building had been constructed of poor materials and was wearing badly. Rotten window frames and leaking roofs (LEA responsibility) needed replacement and maintenance before the classrooms could be refurbished (school responsibility). The toilets were thought to be in poor condition, but, by the time of our return visit, some maintenance work had been carried out, and the appearance of the school was much improved. Of those parents who returned the questionnaire (twelve), half commented adversely on the building. The researcher thought the classrooms seemed overcrowded, a point confirmed by both class teachers.

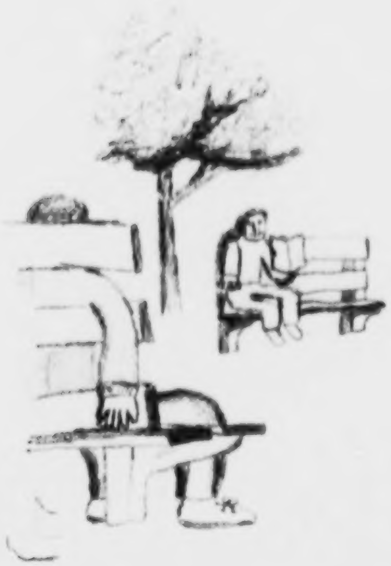


Figure 2.6: 'People are talking in the quiet area.'

The children themselves appreciated the outdoor space; partly as a welcome change from classroom work, but also, more positively, they commented on the opportunities for active play and exercise. The spacious grounds were safe by comparison, for instance, with City or North; for there was no overcrowding to cause accidents and aggression.

Health Maintenance: Exercise

The school had a half-hour mid-morning break and 80 minutes' break at dinnertime. Morning break was supervised by four teachers at a time on rota, one on the adventure playground, two at either end of the playground, and one touring all the pathways. Likewise, there were four supervisors at dinnertime play. The quiet areas were especially favoured by the girls, and the boys dominated the field with football, but, unlike other schools, there was still plenty of room. Wet play was not observed during the field work period, but apparently took place in the classrooms, supervised by the teachers. We cannot say for sure that the spacious and year-divided quiet areas promoted good play and relationships, but certainly children very much appreciated the quiet areas.

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The school seemed well provided with sports equipment, such as tennis rackets, footballs, rounders bats. These were loaned out to children at breaktimes from a central store.

As to more formal exercise, both the younger and older classes studied had two sessions a week of physical education. They also went swimming: the younger ones once a week, the older ones two or three times a term. Transport was by minibus to a local pool.

The acting head thought PE in the school was about average as a contribution to children's health maintenance. She noted that the school was academically oriented and PE tended to take second place. Teachers agreed, and thought there should be more PE, especially since at home, 'The children were not going out as much, playing computer games, watching TV, so they're not outdoors.'

However, it was also evident that there were many sports activities out of school hours, organized by staff and parents. And children were reported as engaging in roller-skating, aerobics, ballet and so on. In the older class, 'only one or two are a bit sedentary'.

Health Care: Accidents and Illness

Like the other five schools, this one had no first-aid room. But it was unusual in that it had appointed a 'welfare assistant' to care specifically for children who were ill, had accidents or needed someone to talk with on health matters. This new appointment started at the beginning of the year 1993–94, and was made in response to the admission of 7-year-olds to the school, thought to need more care. The welfare assistant was a mother, with some first-aid training; she worked officially from 9am to 2.30pm, in practice usually until 4pm. She had a desk (with lockable drawers as records were stored in it), situated in the reception area outside the head's, secretary's and administrator's offices. In addition, all staff had done some first-aid training — as an inset course run by the St John's Ambulance. The children had all done a Red Cross Course. This coverage was thought important, especially in relation to school trips.

At the time of our return visit (summer 1995), two new rooms were about to be built, providing one for the welfare assistant and SHS, and the other for management staff.

All accidents or illness incidents that came her way were recorded by the welfare assistant; on average there were eighteen to twenty entries per day. She said there were fewer accidents in warmer weather because the children were then allowed to use more of the outside space. More serious accidents were recorded in an official Department for Education accident book — an average of three entries per month. The last three entries read:

Cut finger deeply — contacted parents
Hit on jaw by piece of wood — taken to hospital
Burn on hand from semolina — taken to hospital

The welfare assistant's work included helping girls who started their periods. She said this was increasingly common in the school; there were about five in Year 5 and more in Year 6. She kept supplies of sanitary towels and spare pants and acted as a source of advice too. Menstruation was also mentioned by the Year 6 teacher as a topic where the school should take action to provide pleasant, private toilets and cloakroom areas (cf. Prendergast, 1992); and by autumn 1995 refurbishment was in process.

The appointment of a welfare assistant was welcomed by staff. The secretaries had found it hard to combine their work with care, in such a large school. Children also knew whom to go to with health problems, having cleared it with their class teacher. Teaching staff mainly acted as referral agency to the welfare officer; this division of labour saved their time and reduced conflict between varying responsibilities. However, the administrator said the size of the school militated against the personal care of the children; staff and children could not all know each other. In addition, the split responsibility could lead to liaison issues: the administration kept absence records; the teacher knew about the day-to-day health of the children; and the welfare assistant dealt with children's requests for help. The school can be contrasted with Village School, a small school where all staff participated in care of illness and accident. This point will be taken up in the Discussion section.

The school had developed an asthma policy in liaison with a local asthma clinic, and all staff had attended a talk after school by the school nurse and a nurse from the asthma clinic on the management of asthma. The welfare assistant had produced an asthma pack for school trips, she kept inhalers and children came for them when they wanted them. However, it was thought better that the children carry their inhalers with them and leave a spare with her, but the problem here was that doctors would not provide spares.

At class level, the teacher of the younger class had the care of 'several' children with asthma, two with epilepsy, and a child with cerebral palsy. The LEA had adapted toilets for him, and the building was otherwise suitable. The teacher of the older class referred to children with asthma and to those with emotional problems requiring extra care: a suspected abuse case, a child whose mother had multiple sclerosis, and children at risk through parental separation.

Health Maintenance: Food

The school prohibited sweets and crisps, and did not sell or provide snacks. School dinners were cooked on the premises by a catering firm and there were regular meetings with staff to discuss menus. The deputy head rated quality and quantity average; although choice was a strong point, there was too much convenience food. Also, favourite foods ran out, so older children (the youngest chose first) did not always have enough choice.

As noted earlier, only 8 per cent of the children qualified for a free school meal, and only 27 per cent had the school dinner. This was a summer term proportion; numbers were said to be higher in winter. Some of those who did have school dinner commented that they didn't get enough choices — the food ran out before the last people were served, and some said they didn't have enough time to eat their dinner. Most children brought their own food. According to staff, there were two important reasons for this, both connected with the goal of spending time outside: they could eat the packed lunch faster than the school dinner, and during the summer could eat it outside. No-one was reported as going home for lunch.

School dinner was eaten in the hall, adjacent to the kitchen. Children with packed lunches sat on separate tables and all were overseen by lunchtime supervisors. Classes lined up and entered in order, younger ones first, denoted by different bells. Two teachers were usually on duty and had lunch with the children. Other teachers regarded lunchtime as an essential break from children, and did not like to be disturbed by them.

Teachers did not comment on dinners, from a nutritional or social point of view. Though they supervised on a rota basis, they mostly brought their own packed lunches or went out to lunch. The division of labour encouraged them not to consider the school meal as an important part of the school curriculum.

Parents' views were mixed, with some approving and others critical. In the group interview, one thought choice was good, another that there was insufficient fresh food.

Health Education and Health Promotion

The school had appointed a PSHE coordinator, but had not yet formulated a health education policy. However they had studied the national guidelines (NCC, 1990) and found they were already doing most of what was suggested. In 1995–96, the coordinator was to move from Year 6 to Year 4, with the aim of giving her more time to work up a policy.

Health education was taught through cross-curricular methods and through science topics — also opportunistically. Block projects were in place for Year 3 — on Body and Growth; for Year 4 — Environment; and for Year 6 — Sex Education and Bereavement. The school had a specific policy on personal relations (like 22 per cent of our survey schools); it focused on emotional health and bereavement, in part because a child had suffered bereavement recently, and it included policies on playground behaviour and bullying.

Informally, therefore, the school had linked up health education with personal and social education and also with science. The class teachers of both the younger and older children thought the health education curriculum would be improved with more time and attention given to physical exercise; the stumbling block was teacher attitude — 'A lot of the teachers don't like teaching PE — they feel incompetent'. The Year 6 teacher also noted the importance of learning by doing. For example, during the course of sex education, hygiene and diet were discussed:

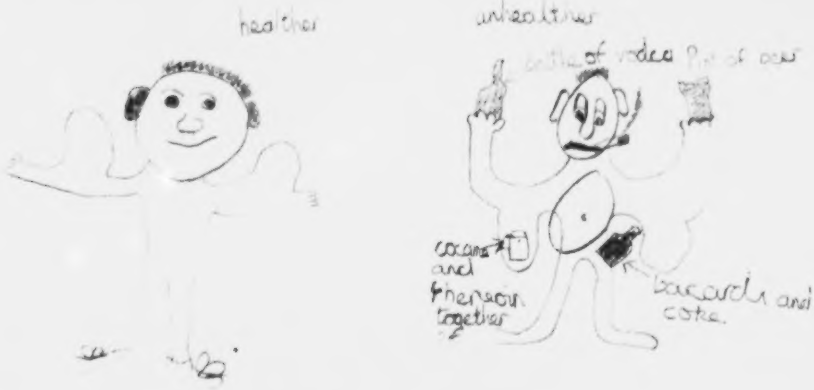


Figure 2.7 Healthy and unhealthy people

> We also then get into eating a healthy diet — in some ways we've lost that because when we had the seventh year here, we actually had — children learned to cook and they were all involved in that and they actually did learn about healthy food and what makes a good diet.

Input into health education by outside agencies was small at this school. The school nurse, like others in our study, had a large caseload, and her only input had been talks on asthma (see pp. 65–6). She also argued that only those trained to teach should teach children. An NSPCC (National Society for Prevention of Cruelty to Children) officer had given a talk on road safety, and a community policeman had talked with Year 6 about drugs.

As in all case-study schools, parents gave top priority to hygiene and nutrition as health education topics; with somewhat higher proportions citing these at County School (eight and six out of twelve, respectively). Parents' worries included cross-infection, the state of washing and lavatory facilities, and the quality of school dinners.

The School Health Service

The school had no specific room allocated for the SHS, which functioned in the part of the entrance area where the welfare officer worked. In the summer of 1995 a room for her and the SHS was due to be built.

The doctor visited six times a year and the dentist once. The school nurse came about four times a term. Given the high numbers of children, visits were not generous; the school fell into the bottom third of junior schools surveyed. Like all the nurses interviewed, this one — with a 23.5 hour week — had a large caseload, with eight schools, including one secondary and a special needs school, where all 130 children were statemented. The nurse commented that a school of this size should have a qualified nurse on the staff. In order to see each child every year, she would have to see forty-six on each visit — the highest number in our six schools (see Table A2.4, p. 243).

The SHS carried out whole class surveillance including hearing and sight checks for Year 3 and Year 6. Otherwise, consultations were by request; a speech therapist and educational psychologist were available for consultation. The universalist screening service was praised by the staff in principle, but thought to be somewhat cursory in practice — children's problems might not always be identified.

The welfare assistant's remit included formal liaison procedures between the SHS and teachers, and with parents. She kept records, sent out appointment letters to parents, kept them informed if referral was needed. She also liaised with the nurse. The teachers, however, seemed to have little contact with the SHS either directly, or through the welfare assistant. Again, this large school had allocated activities relating to medical care and knowledge about it to specific staff. The administrative staff's and teachers' remit and knowledge had less to do with the care, including the medical care of the children, than in our other schools. As one teacher said, when asked about the SHS contribution to the children's health:

> I don't really know an awful lot about it, to be quite honest. I really don't know how it contributes, I have to say in all honesty. I don't know.

Discussion

Provision and Intervention

The school's spacious but poor quality buildings and its very good outside space had been used to good advantage. Recent interventions included the provision of a new heating system, and refurbishment of the toilet areas. Outside they had established quiet areas for each year-group, and three separate playgrounds designated for football, netball and non-ball activities. Children participated in developing and tending garden areas.

The principal innovations, however, concerned the health-care system of the school. The appointment of a welfare assistant and the planned health-care room were responses both to the large numbers of children, and to the inclusion of a younger age-group (Year 3).

In terms of ethos and goals, the school had instituted a range of activities and customs which encouraged high academic achievement by children. These included public praise and systematic awards for achievement. Success in sports was also given a high profile, through displays of cups and shields.

The school had also been fairly well adapted for disabled children. Funding had been obtained to fit ramps and special toilets for a child in a wheelchair. There were also three special needs assistants per day for this child, but the class teacher and the mother both expressed reservations about the extent of his integration. The teacher felt he would be happier in a special school, and the mother felt the school were not doing enough for him intellectually. However, by the time of our return visit, he was thought to be increasingly integrated into the class and school.

Divisions of Labour

This school exemplifies some of the advantages and tensions likely when some aspects of the health-care system of the school are separated out from the teachers' work. Like all school staff, these regarded caring for children, for the whole child, as an essential function of school.

The teachers noted that the establishment of the welfare officer post meant they had 'one less thing to worry about'; the nurse liaised with her rather than with them, and they could send ill children to her rather than cope on their own. Secretaries were relieved of guilt when, because of their main work commitments, they had failed to give adequate caring attention to children. Liaison with the school health service and the educational welfare officer (who came once a week to check on attendance) was well organized.

But the issue of how to maintain the school as a caring environment, given its size and the perceived usefulness of having a member of staff with a specific care remit, was one that concerned staff. Both teachers and non-teaching staff also pointed to the junior age-group as a transition age, where children's need for care and protection began to give way to independence, desired by children and promoted by staff. The Year 3 teacher noted, with regret, that some of the children were 'still dependent' and 'very immature', asking for help and, 'I do get called Mum'. The children themselves seemed to accept the division of labour, although their comments indicate that the welfare assistant, overloaded with requests, sometimes gave them cursory attention.

The teaching staff indicated that their remit included helping children with emotional problems; as generally, they were concerned with the psychological components of learning and their role in sorting through problems and supporting children. The school had recognized the contribution of the supervisors here, to identifying problems and comforting children at breaktimes. Supervisors had therefore been incorporated into all staff activities concerned with caring for the children: staff meetings; the working up of policies, including a school development plan; attendance at inset days. Two of them had attended a bullying course run by Kidscape and had reported back to a staff meeting. The policy of incorporating non-teaching staff in these ways was comparable to that at North School, where PSE policies crossed most features of the school day.

School–Community Relationships

The school had established a range of activities in the local community: for instance, they had raised money for the hospice movement and given a choral entertainment at the local hospice. The school takes part in a local music festival and church services and holds a harvest service for old people. We heard that a school governor had worked on traffic problems locally, in order to improve community relations.

The school also encouraged local people and parents to come into the school and work with it. The researcher understood from conversations with staff that there was a flourishing PTA. Its main function was to raise money and, since children came mainly from well-to-do families, the school was well resourced through parental financial contributions. These included covenants as well as individual donations. At the time of the fieldwork, an outdoor summer fair was being organized, on a large scale, using the extensive grounds of the school. Local businesses were sponsoring such events as raffles. Disabled access had been provided partly through parental contributions, as well as through LEA finance.

Parents also acted as unpaid class helpers, with larger numbers helping in Year 3 than in the older year-groups. The acting head was planning an induction course to help parents tackle some of the main tasks: looking after children in groups, and hearing children read.

The functions of the school in relation to the community seemed to be understood as complementary, in that the school emphasized high academic achievement. The children were being prepared for successful progress through the secondary stage of education. However, parental separation was regarded as an increasing problem, and the welfare functions of the school were seen to extend to offering counselling to parents. Again, it seemed that the welfare assistant took on this work:

> ... they just want to have someone to sit and talk to or have a cry to. We're there as much for the parents as we are for the children. It's a nice school really. We do make it part of the community.

As an academic institution, the school had, in the main, a specific function in the socialization of the children. This function, developed perhaps because of competition with local private schools and the ambitions of local parents, gave it a distinctive flavour among our six schools. As one staff member put it, 'It's healthy for the children academically'. However, as we note below, the school was also concerned for the personal and social education of the children.

Understandings of Children at Home and School

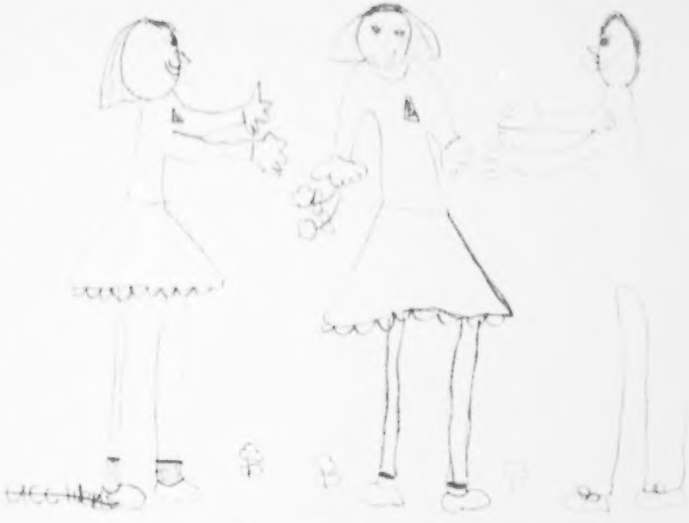
In line with the academic goals of the school, the children seemed to be regarded, through traditional eyes, as there to learn the knowledge required — in this case, nowadays, as required through the National Curriculum. Children observed in classrooms were seated quietly at tables, getting on with paper and pencil work, with the teacher conducting whole-class teaching. Generally it seemed that teachers expected children to be competent, confident and keen to achieve along the lines proposed to them. However teachers found it necessary to give special care to those few children who did not entirely fit in with this model. Examples given were: a child who was 'not very bright'; one of the few ethnic minority children; children from exceptionally poor or 'broken' families. Some of these children were thought to need protection from the comments of the majority and help to encourage them with their work. This vision was complemented by the non-teaching staff's view that the children, especially the youngest, needed care — a caring environment, a person to turn to for comfort.

Because the school was sited in a well-off area, the few children from homes where there was economic hardship, or other obvious problems, tended to stand out, as the teachers noted. This was also the case with the sprinkling of non-white children and, although teachers thought there was no problem with racism, the children themselves described name-calling and hostility. However, teachers did think that, although most of the children were materially very privileged, some were neglected emotionally, and marital break-up was seen as the biggest problem for children. Some of the children were very academically oriented and confident about their position and status in the school, but interviews indicated that there were also some unhappy children; in particular, some boys told us they felt they did not fit in and were always in trouble.

The school had initiated various measures that may have contributed to the children's confidence, competence, and a feeling that this was their school. A school council had been established in 1994, with a representative from each class, and some adult representation. This had so far chosen to discuss and make recommendations on bullying, playtime, organizing dinners and wet breaks. It had drawn up a code of conduct to encourage common good practice through the school. The policy was hung in each classroom; each child had a copy and signed it. There was also a welcome pack for each new child, drawn up by management staff but substantially amended by children on the school council. This provided information about the school to help children find their way and make the best use of facilities. The school had a prefect system, and also a house system which encouraged children to work and play together across the years. The good work assemblies and achievement assemblies focused attention on particular children and on what they had, as individuals or small groups, done. In all these ways, children were encouraged to believe that they were expected to do well and that achievement would be highly valued; also, that they had a part to play in improving the school as a social environment.

The Status of Children's Health at School

The school was well placed to encourage children's health-related activity, with its spacious grounds. As in every school, hygiene and school dinners



An accident.

Some Peaoppea ar
Poshing someyeny over.
and ~~stikung~~ Stikcing there
tong at her. and
ther going to take
her flowers away.
and She is
crying.

Figure 2.8 An accident: 'Some people are pushing somebody over and sticking their tongues at her and they're going to take away her flowers and she is crying.'

were more problematic, given financial constraints. It seemed, however, that formal PE sessions were somewhat fewer here than in our other schools, but perhaps compensated for by the opportunities for exercise afforded by the good outside playspace and the after-school sporting clubs and activities.

This school had appointed a welfare assistant whose functions include caring for children in case of illness and accident, liaising with parents on this, and liaising with parents with regard to SHS inspections (sending out letters for appointments; informing about test results). This can be seen as an appropriate response in a large school to the sheer scale of illness and accident which previously was dealt with by two secretaries and the administrator. In the past, they had sometimes been overwhelmed with calls for help which interfered with their work. The presence of a staff member with responsibility for the care of accident, illness and other health problems removed some of this work from teachers, and may have led to a better service. It also led to a division of labour, as to the care of children, between teaching and non-teaching staff. The welfare assistant's liaison with and for the school health service also probably made for more systematic record-keeping and information provision, but it further removed child-health-related knowledge and care from the teachers' remit.

As with any organization which has clear goals and methods, not everyone will find it to their liking. There was evidence from some children that they found the social order of the school difficult to cope with; and some children, both younger and older, expressed discomfort with rules, discipline and adult unresponsiveness to their requests for help. As regards supporting children's self-esteem, the school aimed to do this through the valuing of academic, sporting and social achievement.

North School

Introduction: The School and Its Environment

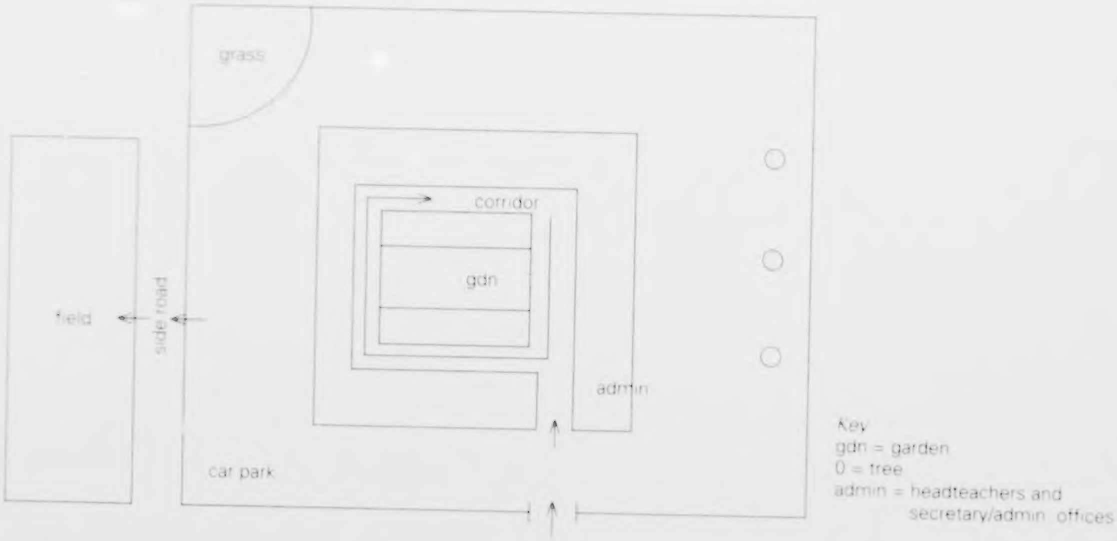
North School, a large junior school with 370 children, is situated in a small-town area of industrial decline on the outskirts of a large town in the north of England. According to school staff, local unemployment ran at 75 per cent, and mobility was high. Those who could find work elsewhere moved out, and it was mainly people who could not afford to live elsewhere who moved in, in some cases after the break-up of a relationship. This account of a poverty-stricken area was endorsed by the appearance of the small town, with its run-down and boarded-up shops, and cramped terraced houses, tightly packed together. The proportion of children eligible for free school meals was recorded at 36 per cent, lower than at City School (60 per cent); but this low proportion may reflect parents' unwillingness to apply, and a preference for feeding the children at home.

The school was sited in a residential area, off the main road. There was little traffic on the road outside the school. Near its gate was a sweet shop, and fish and chip shop. The catchment area was small, with most children walking the half-mile or so to school. There was a good deal of open space in the town, including waste land left behind after the closure of the main industry, mining. The headteacher thought that there used to be a positive community spirit, but this had declined during the last ten years.

The school had a positive policy towards children of travelling families — there was a permanent site nearby. Numbers varied, seasonally, from around thirty children to three or four in the summer. A peripatetic teacher, who spoke Romani, spent small periods of time in school helping with reading and also visited the children at home. She indicated that these children tended to stick together as a group; they were subject to name-calling and to resentment because they were materially better off than most of the children. Such behaviour was regarded in the school as racism. Apart from these children, there were virtually no ethnic-minority children.

Staff said that the children, unlike many nowadays, spent much of their out-of-school time playing locally, round the streets, on designated play areas and on waste land. Parents did not expect their children to be at home or under adult supervision all the time. So school life presented children with a very different regime from out-of-school life.

The children were in fifteen classes, aged 7–11. Class sizes were, in general, smaller than in our other five schools, with twenty to twenty-four


grass
corridor
gdn
admin
field
side road
car park

Key
gdn = garden
0 = tree
admin = headteachers and
secretary/admin offices

Figure 2.9 Sketch map of North School

children. The school had about ninety applicants for 120 places in the first year juniors, which reflected a declining population locally. At the time of the fieldwork, there were 22.5 teachers, two secretaries, four non-teaching assistants, nine supervisors, four cleaners, and a caretaker. This school, together with City and Infant schools, had the best staff–child ratios — 8.6. About half the teaching staff and most of the non-teaching staff were women, and two of the non-teaching assistants were fathers. For the year 1995–96, child numbers were slightly lower at 364, and the school had lost a teacher. As the headteacher noted, the social effects of losing the main industry are felt long after the deed is done.

The School as a Health-care System

School Buildings and Playspace

The school was a 1920s one-storey building, arranged in a quadrangle around a courtyard with a garden. A hard surface playground ran round three sides of the building, surrounded by railings. There was patch of grass and three or four trees, and across a service road was a field belonging to the school. This was difficult to use as playspace, since it required supervision; vandalism and dogs' mess were also problems there. The headteacher rated the buildings very poor (like 6 per cent of those in our survey).

The building had been designed for a secondary school, and had more kinds of spaces than many primary schools. There was a hall and a gym, a library, a resources room, and a kitchen. A corridor ran right round the quadrangle, with classrooms opening off either into the courtyard garden or onto the playground. The courtyard and garden had been developed, with the children's participation, as an 'environmental garden'. Just inside the main school entrance were the secretaries' and headteacher's rooms, both small and cramped. The school health service used the resources room.

As the headteacher confirmed, the buildings were in a poor state and in desperate need of repair; paintwork was drab and peeling. In 1995, the school was trying 'on a minimalist budget' to brighten up the inside and outside environment, but he assessed both as in need of major refurbishment. The heating system was inadequate and needed replacement — it was always too hot or too cold. Classrooms were too small for the numbers of children. The toilets had recently been refurbished and were adequate. The school used to have fourteen cleaners, but now had only four, who found it impossible to keep up with the work.

All the staff interviewed commented adversely on the building and playspaces. One said they needed a new building, and, as the secretary summarized it, they had inherited a shabby run-down building along with Local Management of Schools (LMS) and had great difficulties financing improvements. The Educational Welfare Officer (based in the school) noted that

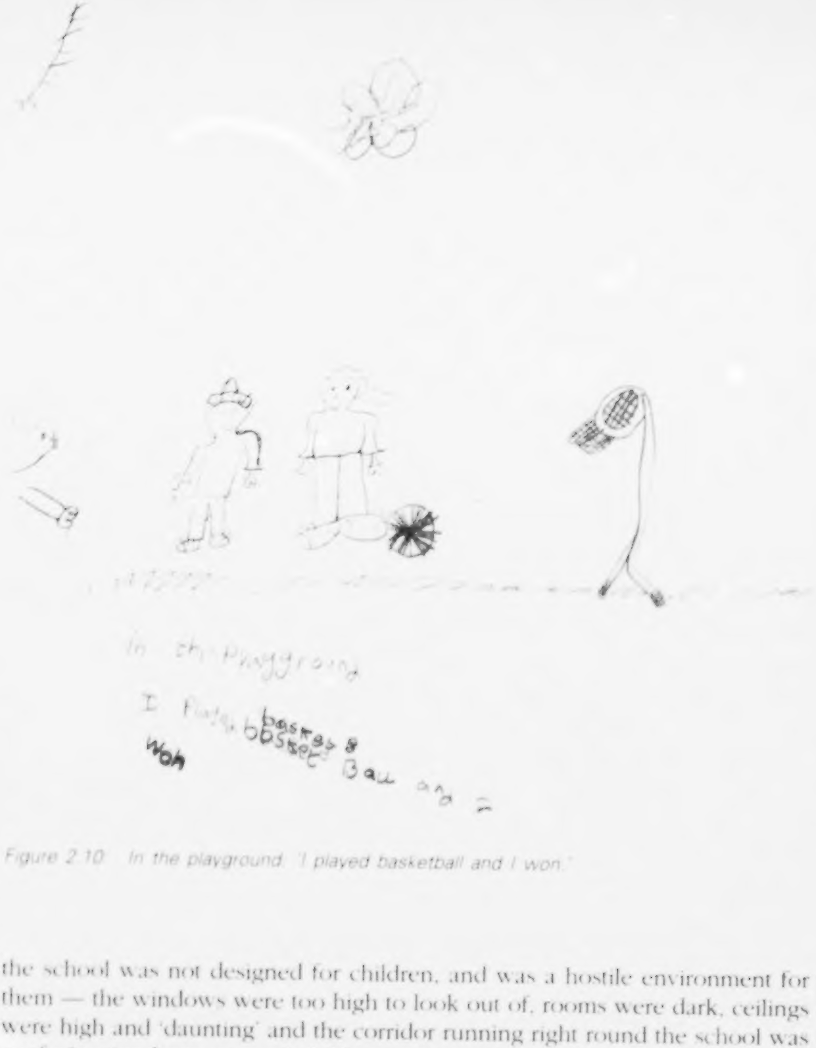

In th Playground
I Plated basket basket Ball and I
won

Figure 2.10 In the playground: 'I played basketball and I won.'

the school was not designed for children, and was a hostile environment for them — the windows were too high to look out of, rooms were dark, ceilings were high and 'daunting' and the corridor running right round the school was confusing (and encouraged children to run round!).

The children, looking back on when they first came, noted how large and confusing the building was; their comments also notably focused on the value of the quiet places at school, in particular the library.

Parents were accepting of the physical environment of the school — though the buildings could do with 'a lick of paint', they were adequate and the state of the school did not affect the children's education. It was also important, as one parent said, that the school was nearby, and not on a main road, so the children could walk to it safely.

Health Maintenance: Exercise

The playground and its equipment was rated very poor by the headteacher and, likewise, the children's opportunities for play were also very poor. He noted that facilities for PE (the field and the gym) were good but that the school did not provide changing rooms or showers.

During the 15 minute mid-morning break and the one-and-a-quarter hour dinner break, the children played outside on the hard surface playground, with each year-group having a space marked out. They took turns for access to the grassed area. There appeared to be plenty of space to play, and apart from some marked out games (such as hopscotch), children devised their own entertainment. Morning break was supervised by four teachers on a rota, one for each play-area, and dinner break by four supervisors. Many of the older children played rowdy games and frequent fights were intercepted by supervisors.

At the more formal level, all classes had PE lessons twice a week, in the hall or the gym. And classes in Years 5 and 6 went swimming at the baths situated over two miles away. According to the headteacher, these trips were problematic because the bus rented to transport the children was often late.

Compared to other case-study schools, staff at this one did not discuss curricular exercise in much detail. Our impression was that caring for the children and raising their self-esteem had higher priority than PE (see below under Health Education). Two of the teachers noted that the school was conforming to the National Curriculum guidelines as to the quantity of exercise. And one of them noted that having to be purposeful about making sure children learned certain skills during PE lessons was off-putting. It also seemed that staff were daunted by the poor building and outside space as regards promoting PE. One parent noted that the absence of a usable grassed area limited possibilities for organized games.

Health Care: Accident and Illness

One of the secretaries had long first-aid training (with a refresher course every four years), and so did three of the supervisors. Two teachers had done short first-aid courses. As in most schools (90 per cent), there was no designated first-aid room — children were cared for in the (very cramped) secretaries' room, and if need be they sat in the corridor nearby and waited for parents to pick them up. First-aid equipment, and other medical equipment, such as inhalers, were kept in the secretaries' room, an arrangement advised by the local GP surgery but contrary to the headteacher's view.

At the time of fieldwork there were no written guidelines or policies for dealing with accident and illness, but the secretary was producing guidelines for accidents. At the time, only 'severe' accidents — involving visits to Accident and Emergency departments — were recorded; but parents were informed about all but very minor accidents and about all bumps to the head. Children needing treatment for accidents were taken to hospital in the large town, five miles away.

It seemed that there was a clear division of labour for the care of children with accident or illness: care was seen as the domain of the secretary, with referral back to the parents if need be. (This is somewhat like City — a similar size school; and unlike Infant and Village — smaller schools where roles were blurred.) The secretary was happy to be the designated first-aider. She liaised with parents, and sometimes took children home in her car (because there were only two buses an hour locally). She also worked in conjunction with the midday supervisors who cared for the children if she was out of the building at lunchtime.

All the five parents interviewed were happy about procedures as regards accident and illness and thought liaison between the school and parents was good.

Health Maintenance: Food

The school was pro-active in trying to influence children's diets. Sweets and crisps were prohibited in school (compared to 4 per cent and 39 per cent of survey junior schools), but sweet shops and the 'chippie' were very nearby and children (with parental permission) commonly went out at lunchtime and bought snacks. Staff lamented the fact that they had no control over children's food consumption apart from the school dinner.

Four-fifths (297 of 370) of the children had school dinners, with the rest bringing packed lunches or going home. As noted earlier, a third of the children (120) had free school dinners. The food was provided by the local LEA catering service and cooked on the premises. Multiple and vegetarian choices were provided, including salads and fruit. The head rated the meals as good in terms of both quantity and quality. He explained that the school had been next in line to introduce the 'traffic light system' to encourage healthy choices, but 'the funding ran out before it got here'. According to the cook, planning of food provision depended on take-up and staff kept records of consumption. For instance, if only ten children habitually chose salad, in future only ten salads would be provided. The cook also noted that children preferred processed food to fresh. These efforts at liaison and planning paid off in terms of children's appreciation of school dinners — more commonly mentioned than in other case-study schools.

The meals were provided in the hall (for the younger two years) and the gym (for the older). The food was laid out on a counter and the children queued up, class by class. About half the teachers sat and ate with the children at the time of fieldwork, but by the time of our return visit this number had dropped, since the school could not longer afford free meals for staff. One of the teachers said sitting with the children was important to make the dinner time a social occasion and to encourage healthy choices; he noted that some of the children seemed unaccustomed to the idea of the mealtimes as social occasions, with conversation during eating. The supervisors also noted the teachers' function in making dinnertime a civilized occasion: the gym, where the older children ate, tended to be noisier and rowdier than the hall, where the younger children ate and where the teachers, on the whole, chose to sit. The supervisors saw their own role as including discipline, as well as organizing the provision and clearing up of the food.

At a more general level, staff noted conflicts between a health education policy which promoted healthy diets, the provision of choice — which allowed children to choose unhealthy food — and the ready availability of snack foods just outside the school gate.

Health Education and Health Promotion

This school had both a health education coordinator and a PSE coordinator. Health education was increasingly seen by staff as an important component of school life, together with work on personal and social education (PSE). This emphasis on promoting children's psychological and social health was evident in staff interviews, as a major function of the school. In part, the impetus for this work was the general feeling among staff, led by the headteacher, that the school should compensate children for their poor and often disrupted family backgrounds.

A health education policy document was drawn up in 1994–95, using the local council's guidelines on safety and National Curriculum Council guidelines. Health education was incorporated through a spiral curriculum across all years, and in block projects, through topics and as the opportunity presented itself. The policy was distinctive in identifying health and safety issues in the local social and physical environment. Thus it drew attention to local dangers, — disused industrial land and stretches of water. Road safety programmes included cycling safety awareness education, and these were top priority — which no doubt reflected the fact that the children were likely to be out and about on their own. Within the school, against some staff opposition, the health education coordinator had followed LEA policy and instigated a no smoking policy; and she was campaigning to have fashionable (and expensive) clothing banned from school, especially items with motifs relating to drug-taking and guns.

The school had some help from outside: a local police officer talked with the children about road safety, and the school nurse did a session on puberty with Year 6 children.

The PSE coordinator had also produced policy documents for staff and for parents. These were influenced by Lee and Marlene Canter (1993) whose work stressed behaviour modification through assertive discipline. In this school, a programme with the general name 'positive teaching' had been worked up

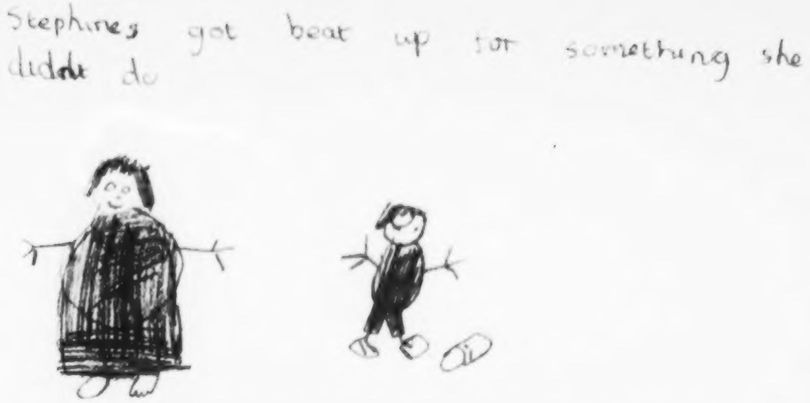

Stephines got beat up for something she didnt do

Figure 2.11: An accident: 'Stephanie's got beat up for something she didn't do.'

over a period of four years to improve the self-esteem of the children and thereby help them be happier and more productive at school and at home. The policy document was addressed to both teaching and non-teaching staff, and stressed reinforcement of good behaviour in class and at other times (dinnertime, playtime), through verbal support and through the issuing of certificates praising the children's behaviour and achievements. Information about this policy was also set out in a document for parents. Both documents also dealt with bullying, and stressed the importance of helping both victims and perpetrators, and of rewarding non-aggressive behaviour. These documents were displayed on a noticeboard near the main entrance, together with a box where anonymous reports of bullying incidents could be posted by the children. The children reported on incidents of fighting and bullying, and were appreciative of the system in place to deal with these problems.

Though the teaching staff regarded the supervisors' work in positive reinforcement as important, the supervisors themselves identified some difficulties. Not surprisingly, given their role in monitoring and disciplining the children outside the classroom, their views on the children differed from the teachers'. They thought the children did not respect them, regarded themselves as the bottom of the hierarchy of adults at the school, but had the hands-on job of sorting out problems of aggression and bullying in the playground and referring 'up' to the teachers. They also thought the children needed tougher discipline, and that the school should impose this.

> If there's a problem out in the yard, they [children] have to come and see us and then we ask, and if we think it's a problem they have to see the teacher . . . It goes higher than us, to the teachers. If it's the travellers: the others picking on the travellers, usually [the headteacher] gets involved with that.

The researcher saw three instances where children lined up and chanted at the supervisors, evidence of hostility sparked off by incidents where children felt unfairly treated by them.

The School Health Service

As in most survey schools (70 per cent), there was no specific room for the school health service; it worked in the resources room. Visits by the school nurse compared favourably with the national picture — she visited once a week (as in only 17 per cent of survey schools). But the doctor visited only once a year (as in 19 per cent of survey schools), and so did the dentist (compared to 71 per cent). At the time of fieldwork, the school had had three nurses over the previous three years; the nurse had just left and a new one had started. She was preoccupied with a measles immunization programme across the school years. Doctors were so rarely sighted that the headteacher did not know whether personnel had changed. The school also had visits from a health visitor who advised on children with specific conditions, and provided contact phone numbers for expert information and help.

In this area, a pre-school check was carried out, rather than a reception class check. Hearing, sight and dental checks and health interviews were carried out routinely for Year 6 children, and consultations on request for other children. Both the headteacher and health education coordinator were satisfied with the school nurse's contribution to health education, as far as it went, but thought more input was desirable, for instance on diet, hygiene and lifestyles generally. As in all the schools, staff commented that SHS input had been reduced, and comprised referral rather than direct help. One teacher argued that the children could no longer 'identify with it' — the type and level of service was such that they could not think in terms of it as a service that looked after their health.

Though liaison was formally with the headteacher, SHS staff contact was mainly with one of the school secretaries. She kept records of all children with medical problems and tried to keep the nurse aware of these. She contacted the nurse if the school had identified a problem. She also managed the practicalities of sessions: getting the children out of the class; lining them up and holding their hands; and helping to organize the nurse's work. Liaison with class teachers and with parents was on an informal basis only.

An important feature of the health-care service was the work of the educational welfare officer, who had worked for many years in the area, and was based in the school. His work included helping with the social problems faced by families locally. The educational welfare officer indicated that he had a coordinating role with the school nurse to tackle children's problems, for instance through home visits to help parents with diet or the management of asthma. Also, where a child was doing badly at school and parents said a health problem was the cause, then.

> . . . I have to work very hard with the school nurse in offering a positive service to the family on the basis that — let's rule out the health issues that might be affecting the child's life at school, before raising the issue of — what the hell are we going to do about him or her if there's nothing wrong [healthwise] . . . and then you begin to realize that . . . it's not the child's problem necessarily but it may well be that the parent can't relate to — can't understand how to engage in dialogue with the school to work out how to solve the problem.

Discussion

Provision and Intervention

The school had poor quality buildings and playspace, and financial constraints had inhibited the fundamental work required to make them suitable for the children. The school drew its children from a deprived catchment area, and one where most parents did not readily take part in the life of the school. Furthermore, falling rolls meant a lower budget for the school, and compounded its difficulties in improving the environment for the children.

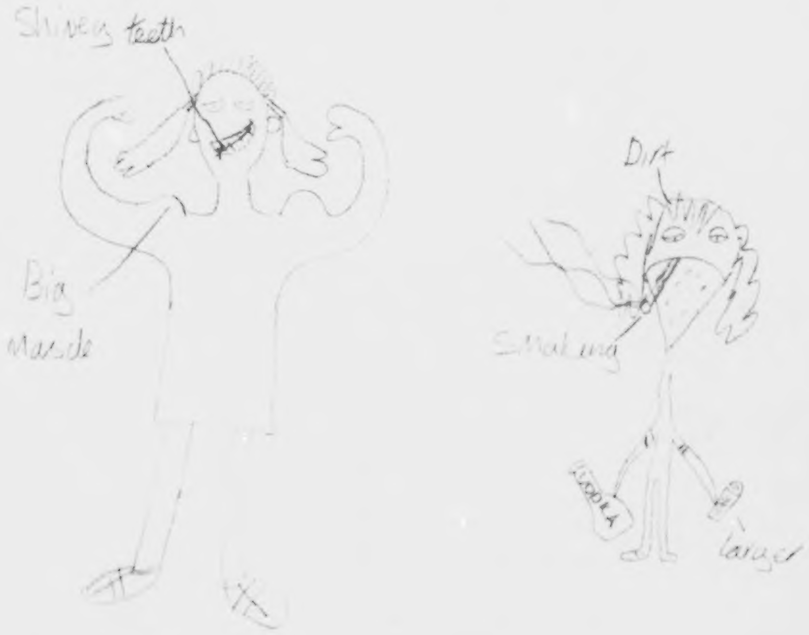


Figure 2.12 Healthy and unhealthy people

The school's response to these problems was compensatory, to raise the children's self-esteem through positive reinforcement, and to strengthen them psychologically through a PSE and health education programme that encouraged discussion of issues of concern to the children — such as bullying and aggression. There were many indications that staff conceptualized school as a social environment where personal relationships and acceptable behaviour were matters that should concern children and adults alike. Thus dinnertime and playtime were seen as occasions when the adults should encourage and reward good behaviour. The presentation of certificates for good behaviour and for trying hard is another indication. The postbox for reporting bullying episodes is another.

Though the school could not control the children's diets, in the face of commercial pressures, the health education policy proposed food preparation (in the science and technology curriculum) as a focus for education. There was also some informal liaison between the health education coordinator and the school cook to ensure healthy food preparation (for instance low fat, no salt in cooking).

Divisions of Labour

Caring for the children in the sense of positive teaching, rewards and encouragement were understood by the teaching staff to be functions of all staff; and there was a clear sense of team commitment to these school policies. Given that the school was sited in this area of high unemployment, teaching staff thought maintenance of high morale was a priority. According to the PSE coordinator, the PSE policy ensured that,

> ... the children feel safe. They feel they can share a problem with a variety of people. There is always somebody, because it's a whole school policy, who will listen. They know that whoever it is will deal with that problem in exactly the same way.

Supervisors, however, who faced the children in their 'free time' and dealt with some aggressive behaviour — outside in the playground and during dinner — were not entirely sympathetic to this idea. And the educational welfare officer, from his professional perspective, added the point that people need to be trained to do counselling — it can't just be assigned to people as part of their job.

The physical care of the children in case of illness or accident seemed to be delegated to the secretary who appeared confident and capable, as well as trained, for this work. It was she, too, who carried the main liaison role with parents. The secretary was also the person who oiled the wheels of the SHS staff visits to the school, in terms of providing information to the nurse, making sure the children were got ready to be seen, and, again, purveying information to parents.

School–Community Relationships

The school had no formal PTA, but had a range of initiatives to encourage parents to come into the school, including meetings for parents of new children, the provision of a very friendly booklet explaining the PSE policy and another called 'Adult Helpers in School' which provided information about how they could help in school. Parents also received the certificates praising their children's achievements.

But the school had difficulties in getting the parents to cross the home–school barriers. The main reason proposed for this was that unemployment and its attendant problems left parents no time or energy to give to the school. Some parents were thought to have bad memories of attending the school (then secondary) themselves; others to resent differences in values between home and school; and others to devalue school, as a compulsory rather than beneficial institution.

The school reached out to local people through the work of the educational welfare officer — unusually based in the school — and the health visitor, who was based in a health centre locally. These staff kept school staff aware of links between children's daily lives at school and at home, and attempted to ameliorate problems in either setting.

Another kind of activity directed outwards was through the establishment of a health education curriculum which took account of social and physical conditions locally. For instance, health education topics included work on local hazards, including dangerous stretches of water and toxic waste. This school, like Village School, notably sought to link school work with local issues, and thus make them meaningful and useful for the children.

The staff, in general, thought constructive school–community relationships important or even critical in the locality. Since the mines closed — the main employer — local community spirit had broken down, families were increasingly split, and there was no central focus to draw people together. So the school remained the main organization and setting where people could get together with common interests. And staff noted, non-judgmentally in the main, that good school–parent relationships would form the basis for facing social problems in family life. However, given low local morale, building strong school–community links was difficult. This situation is in marked contrast to that at, for instance, Village School, where the school was able to tap into flourishing local community institutions and relationships and build on them.

Understandings of Children at Home and School

Home life was seen as, ideally, the basis of children's well-being and self-esteem. All staff noted that many of the children did not have 'much of a home life' and that school should compensate for this poverty of experience. School was described as providing a family or a home for the children.

The independence of children outside school hours was a source of worry to staff; parents should order children's lives to enable them to benefit from school, and this included not encouraging undue independence.

> We do ask some of our children to lead very different lives between the hours of 9 a.m. and 3.30 p.m., in that they're very self-sufficient before and after that, and find it difficult to be settled [at school]. Because by self-sufficient I mean they come and go as they please at home, which might be wider hours than we would think acceptable for a child. So they're often tired.

There was also a strong feeling among staff that children's lives at school were being distorted by the National Curriculum. The idea of caring for the whole child, and encouraging self-esteem and a constructive creative approach to work, conflicted with the demand for children to conform to set regimes and kinds of learning. The headteacher regarded testing, in its present form, as a waste of time and counterproductive.

The Status of Children's Health at School

The psychological health of the children had very high status — promoting it was seen as a central function of the school. The physical health of the children was perhaps of somewhat lesser concern, in that PE sessions followed National Curriculum guidelines, rather than being allocated high priority. On the other hand, the children had plenty of space to run around outside, and locally.

Thus the compensatory effort of the school focused especially on self-esteem through psychological approaches. The concerns of the SHS and the educational welfare officer were mainly with the behavioural rather than the physical health of the children. It is interesting that the two schools serving especially deprived populations — City and this one — both deliberately aimed to compensate for the children's social disadvantages.

The staff at this school valued the children's own contribution to learning and to the social strength of the school; they downplayed the contribution of the National Curriculum to the children's well-being, now and for the future. High achievement in terms of perfectly presented work (as at Infant School) or in terms of academic success in national terms (as at County School) seemed lower on the agenda than the old virtues of children learning at their own pace in a happy social atmosphere.

Infant School

Introduction: The School and Its Environment

Infant School is situated in a residential area between two villages on the outskirts of a large northern town. Its main catchment area was about a mile — the children came from socially mixed housing in the two villages and were almost exclusively white and indigenous. The area was one of industrial decline, and the housing comprised Victorian working-class housing, more recent council housing, and new housing reflecting the gentrification taking place over the last ten years. As a measure of poverty levels, 29 per cent of the children were eligible for free school dinners. The school was situated on a main but not very busy road, with no shops in the immediate vicinity. The children were almost all accompanied to and from school, and came mainly on foot or by bus.

There were 150 children aged 4.5 to 7 years, in five classes, with an average class size of thirty children. Like North School, this school was undersubscribed because of falling population locally, and it had one empty classroom. There were also two nursery classes in a separate building set in its own grounds, linked by a path to the main school. The main school had six full-time teachers including the headteacher, one secretary, three part-time non-teaching assistants, one special needs teacher (three hours a week), six lunchtime supervisors and a caretaker. All staff were female. Though teacher–child ratios were, as the headteacher said, not good, if one takes all staff into account the school had a good staff–child ratio of 8.3. This puts it in the top three of our case-study schools, along with the two in the most deprived areas: City and North.

The School as a Health-care System

School Buildings and Playspace

The building dated from the mid-1970s and reflected educational ideas of the time. It was open plan with classroom areas in blocks of two, each with its own toilets and washbasins, and with a shared tiled art area between the classrooms. The main entrance was to a large open space and the secretary's and head's offices had large windows and opened onto it. This space was used by the school health service. There was a large hall, used for assemblies and music and equipped as a gym.

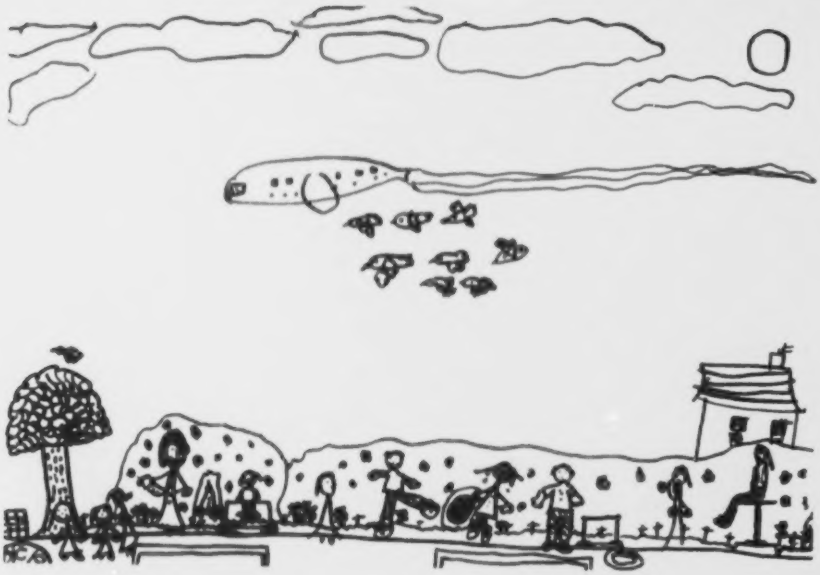


Figure 2.14 'Me at school'

It is notable that this was the only one of our six schools being used for the purpose for which it was designed — as an infant school, with delivery of the curriculum based on team teaching, project work, and art and craft work.

The standard of decor and cleanliness was very high and great attention was given to displays of plant and flower arrangements and to displays of the children's art and topic work. The headteacher rated the building overall as average, and the classrooms' heating and ventilation as average, toilets as good, cleaning as very good, but natural light as poor.

Staff united in considering the staff toilets as completely inadequate; there were only two for all adults — staff and any parents or others on site. Since the first-aid equipment for the children was also in one of these toilets, the situation was regarded as poor.

The children's toilets were all inside the building (unlike City, Town and Village), and looked clean. However, some children, as in all schools, complained that the toilets smelt bad.

The playgrounds and grounds generally were very spacious and well kept. There were two hard surface playgrounds painted with games, with one reserved for the reception class and the other for the older children. There was an extensive grassed area, bordered with hedges and trees. There were also flower and shrub beds, cultivated by a retired teacher who worked with the children on these, and a fishpond built by the children.

All the staff expressed pride and pleasure in the physical character of the school as an environment for the children. However, as a working environment, the school attracted some criticism. The fabric of the school included plastic wall-covering which led to condensation and thence damp and dangerous floors in winter. The classrooms were heated with blow heaters which produced a dry heat and were noisy. The school generally was thought to be noisy — because it was open plan, and perhaps not the ideal working environment for children. However, staff could take children into the quiet book areas, or into the hall.

Almost all the parents thought the buildings and playspace of high standard, but mothers in the group interview thought security was a problem — the carpark gate was sometimes left open and they thought anyone could walk in.

Health Maintenance: Exercise

The school grounds provided plenty of space for the children to run around and play, and the headteacher rated opportunities for play very good. Morning and afternoon playtimes (both quarter of an hour) were supervised by one teacher and one supervisor — one to each playspace. According to both observation and report, the adults organized ball games and skipping with the children, and there was also some play equipment and quiet areas so that children had choice about types of play.

Though there seemed to be a high level of supervision at playtimes, this school was not exempt from the general pattern — high proportions of interviews with children (nine of fourteen interviews) included comment and fear about violence and bullying: 'people pushing me and fighting'; people running round and I'm scared and someone grabs me round the waist and pulls me over'; 'I don't like people fighting me; and people skidding at us'. On the other hand, the environment, both outside and inside, called forth praise. Children liked the playground 'because it's bigger' (compared to nursery); and enjoyed the opportunities for play and exercise, skipping, doing apparatus, playing out, playing on the grass. Compared to children in the other five schools, children here made an unusually large number of positive comments about various parts of the building: the classroom, the quiet book areas, the hall, where they did gym and dancing.

The children had three half hour sessions per week for PE, in the hall or outside in good weather. These included gym, softball games and dance/movement. They did not go swimming because of organizational difficulties — the nearest baths were some distance away. Parents in the group interview regretted this.

A teacher noted that having a separate playground for the youngest children helped prevent accidents to them, the layout of the school meant that staff could see the children all the time — there were no hidden corners.

Figure 2.15 In the playground: 'I am playing games in the playground.'

Health Care: Accidents and Illness

In this school, high proportions of staff had first-aid training: the head, a teacher and two non-teaching staff had long first-aid training, and one of these NTAs (non-teaching assistants) was the designated first-aider (she worked a 20-hour week). The secretary said that children tended to come to her if they needed help, and she would do first-aid if no-one else was around. (Note: for definitions of short and long first-aid courses see p. 38.)

The school had written guidelines on accident and illness, and also kept an accident book. Parents were informed of all accidents. Serious accidents were entered into an official LEA book.

As noted, space to care for the children was a problem: first-aid equipment was kept in the staff toilet and immediate treatment was sometimes given there. The children were generally cared for in the central open space, with the disadvantage that this was very public, but the advantage that the headteacher and secretary could keep an eye on the children. Children could also lie down in the head's office.

The headteacher noted that caring for children with chronic conditions was particularly problematic. For instance, a child with cystic fibrosis needed frequent care, including a place to lie down — so he would lie in the head's room. Similarly, children with asthma had no place for self-medication, apart from corridors; inhalers were kept by the senior supervisor and used during the dinner break.

In considering local community and health services for children with special needs, the headteacher had drawn up (in 1994) a chart of service providers (see p. 220) and listed the alterations — mostly reductions — in provision in recent months. These included staff leaving and not being replaced, and increases in staff workloads. The people and agencies included: educational psychologist (worse); hospital (worse); school nurse (good); health visitor (worse); school doctor (worse); speech therapist (worse); teaching support (worse); educational welfare (better); non-teaching assistants (worse, but one new person for 1995–96); teachers (larger class sizes); administration (worse); inspectorate (worse); and, finally, funding was now inadequate to match running costs each year. The effect of these service reductions was much poorer levels of expert information, advice and help. She singled out, in particular, the speech therapy service as poor: it had insufficient staff to address referrals and to carry out speech and language programmes. On our return visit we heard that these problems were continuing for the new school year 1995–96.

However, for the year 1995–96 the headteacher had secured a special needs assistant to help with the care of an autistic child (funded from the LEA budget). She put her success on this down to constant following-up of documentation and persistent liaison work. She also noted for this year that a Service Level Agreement with the Education Welfare Service had resulted in a weekly visit from the educational welfare office, with greatly improved follow-up work.

Health Maintenance: Food

The school provided milk at the morning break, free for those eligible for free dinners and £3 a term for others. Sticky drinks were banned. Some mothers said their children complained that they did not have enough time to drink their milk; staff noted that some children drank slowly — so that they could stay in and chat rather than go out. No doubt both sides had a case! Both staff and parents deplored the lack of drinking water for the children — the only drinkable water was in the staffroom.

Most children stayed for school dinner with few having packed lunch or going home. As noted earlier, 29 per cent of the children were eligible for free dinners. The dinners were provided by the LEA catering service, cooked at the adjacent junior school and delivered on trolleys. Children ate in their classrooms. The children had a quarter of an hour to play outside and wash their hands, while the supervisors set the tables, six to eight children at each. No adult sat with the children, but the supervisors served the children and monitored their behaviour.

Teachers and supervisors stressed that dinnertime was an important social feature of the day and encouraged the children to make dinnertime a civilized occasion, with good table manners and reasonably quiet talking. The children said grace before eating.

There were no choices or vegetarian options, no salad or fresh fruit, but children did not have to eat foods they disliked. The food was 'traditional English' in character: meat and two vegetables followed by cooked puddings or yogurt-type desserts. The headteacher rated the school dinners very good in terms of both quantity and quality. Liaison between the school staff and the meal providers was on an ad hoc basis and, as at most schools, children had no part in it.

Staff indicated that children enjoyed the dinners, and that nutritionally they were as good as possible, given depleting budgets and consequent use of pre-processed food. The school meals adviser was particularly concerned at conflicting government policies: both encouraging cheap fatty convenience food and stressing individual responsibility to consume healthy food. Teachers also liked the classroom dinners. They thought mealtime in this familiar, small-scale setting was more child-friendly than the usual cafeteria system in a big hall.

The twenty-nine Year 1 children, as is general for younger children, identified food as the factor that kept them healthy, and they went on to note that the main healthy things they did at school included: food (sixteen), exercise (ten) and work (six). Three children mentioned food and exercise and two mentioned work and exercise. Many praised the school dinners, but fourteen of them said that some aspect of food at school was unhealthy — junk food, or sweet food (which could refer to the snacks they brought in as well as to sweet puddings).

Health Education and Health Promotion

Whereas in larger schools a teacher is generally allocated responsibility for health education, here the headteacher acted as health education coordinator. In practice, this meant that not only the formal education curriculum, but the more informal health promotion curriculum, owed much to her approach. The combination of small school size and the headteacher's participation in health promotion from her position of influence resulted in unusually coordinated whole school health promotion policies and practices. Compared to infant schools in our survey, this one was distinctive in its attention to health education and promotion; only 5 per cent did as much.

The school had a clearly worked out curriculum for health education based on LEA policy and the NCC guidelines. It ran across the school years and was taught on a cross-curricular basis, through science topics and opportunistically. There was a block topic for the oldest children on the body. Visiting speakers included the school nurse (diet, hygiene), other community health staff (dental care), and police (safety).

Staff indicated that outside the formal curriculum, there was emphasis on

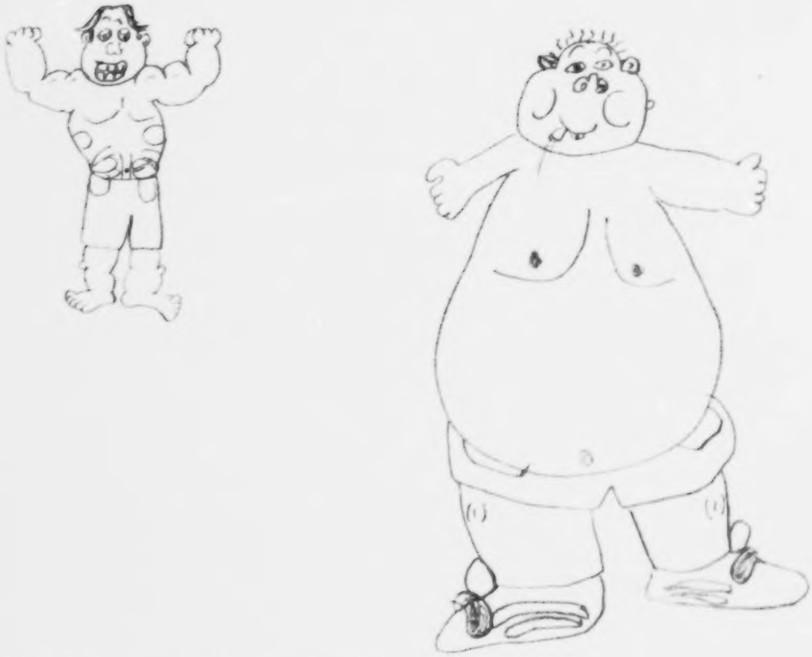


Figure 2.16 Healthy and unhealthy people

hygiene and safety, and these, as well as diet, were the main topics parents wanted taught to their children. Unlike most schools (86 per cent), this one reported having specific health-promotion policies in more than four areas: safety, personal relationships, risky activities, personal health and dental care.

As suggested earlier, the school gave unusually high status to enhancing the physical appearance of the building, through displays of children's work, and this provided a pleasant working environment. The children were involved in improving the school grounds, through gardening, and staff intervened in both playtimes and dinnertimes to promote good social relations.

The School Health Service

The school health service had no designated room in the school but operated in the central open space. The nurse visited once a week, and discussed cases with the headteacher, who valued this regular contact. The frequency of nurse visits was high by the standards of our survey: only 10 per cent of schools reported this level of input. However, service from doctors was poor: a yearly visit had been the norm, but the doctor had left and not been replaced. As with 71 per cent of survey schools, the dentist visited annually. In terms of visits per child (see Table A.2.4, p. 243) the school scored well — the nurse would have to see only 4.5 children on each visit in order to see all over the course of a year. The headteacher rated the service as poor overall; though the intent was good, the practice was inadequate in quantity and quality. She was particularly concerned about local service input as regards special needs children and had worked out a detailed list of recent reductions in services.

The class teacher and secretary also valued the nurse's regular weekly visit which allowed them to consult and refer. Speech therapy was a particular teacher concern. The secretary liaised between the nurse and parents, giving out appointment letters. The nurse said she spoke each year at a morning meeting for reception class mothers to introduce herself, explain the service, and to give out a contact card — in accordance with the Patients' Charter.

In this health authority area, children were given a pre-school check, rather than a school entry medical. From the point of view of primary school staff, this system can mean poor information and liaison as regards reception class children, as the Town headteacher noted. At Infant, most of the children moved up to reception from the on-site nursery class, so liaison and continuity were facilitated. When children joined the reception class their parents were asked to fill in a health history, which also allowed them to ask for a health check if they wished. Referrals for checks and specific concerns were also made through the health visitor, GP and school staff.

The group interview with parents showed, as commonly, that mothers had had little or no contact with the school health service, did not know that the nurse came each week and did not see it as an important service for them or their children. In case of health service need, they would go to their GP.

Discussion

Provision and Intervention

This school had a very pleasant, welcoming appearance. It was approached along a wide, paved path with planted areas, and had a wide entrance and spacious central area. The classrooms and their adjoining art areas were well equipped, and seemed spacious, light and airy. There were exceptionally spacious playgrounds and gardens. Some features of the building (heating, ventilation, damp) were less than adequate, according to staff, and staff toilets were completely inadequate in number. The absence of a first-aid area or room was particularly remarked on. A further positive characteristic of the school was its smallness: staff noted that they knew every child, and that roles were interchangeable in that children could go to anyone and be sure of getting help.

There was great stress on making the building look attractive, and in showing off the children's work to advantage. Displays of art work and project work were the result of hard work, including work by the children. The building was also kept very clean.

Most of the staff noted that class sizes had risen and the large class (about thirty children) was seen as a serious disadvantage. It made for difficulties in giving individual attention, and in particular in caring for children who specifically needed individual help. As the non-teaching assistant said, you 'feel like mothering them', but with thirty children that was difficult.

The headteacher endorsed staff concern and at the time of fieldwork said she was giving priority to buying-in help — the school had a special needs helper (3 hours a week) and three non-teaching assistants (2.5 FTE). However, as noted above (p. 139), she was pleased to have secured help for one child for 1995–96.

Divisions of Labour

With only six teachers, and with an all female staff, it seemed that demarcations between roles were blurred. As the class teacher said, everyone had been a mum, and their comments on their work reflected this:

> The children do get cuddles when they're poorly, they do get cuddles when they're upset [and if they have problems] we hope they're going to open up to us, which they usually do. We're there to listen.

The informal lay health-care system operating here, and dependent on women turning their hands to whatever need occurred, was similar to that at Village School.

The school operated with an interesting blend of the informal lay health-care system, and some carefully worked out policies, for instance on the appearance of the school, and on health promotion. Thus school staff seemed to work together responsively in the children's interests, within the framework of the policies established and led by the headteacher. The children were both protected within this framework and encouraged to participate in contributing to the social order of the school.

As commonly found in primary schools, it was the secretary who did much of the liaison with the health service, and the head who was the formal link with it.

School–Community Relationships

The headteacher indicated that the school benefited from input from parents and from a range of local people, as helpers in class and on trips, and in the

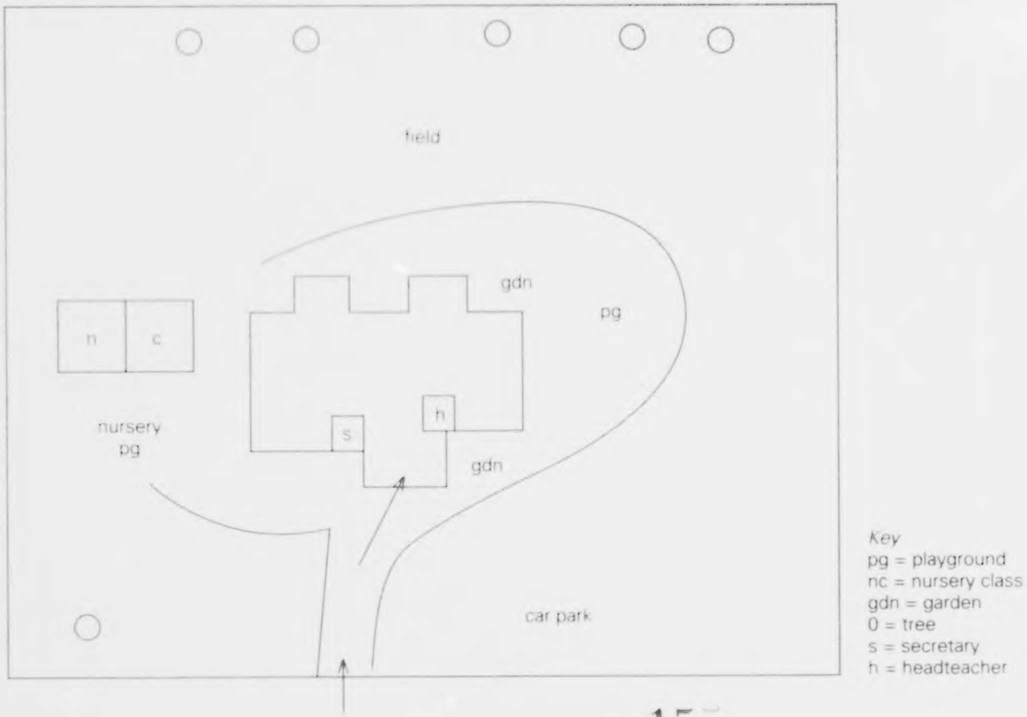

field
gdn
pg
n
c
s
h
nursery
pg
gdn
car park
Key
pg = playground
nc = nursery class
gdn = garden
0 = tree
s = secretary
h = headteacher

Figure 2.13 Sketch map of Infant School

gardens. A Friends of the School organization was important mainly for fund-raising. As regards the input of services for children, she had an unusually precisely worked out understanding of what services were appropriate and how these had changed — for the worse in recent times. However, the school was able to attract experts to talk with the children on health education topics.

Specifically as regards parents, the school provided a prospectus which listed the skills children should have before they started school. Frequent contact was maintained, since parents both brought their children into the classroom and collected them there at the end of the day. As in other schools, the expectation was that a parent would be available to take a child home in case of illness or accident, and staff reported no difficulties on this. Good relationships were indicated by the virtual absence of parent-blaming by staff.

It appeared that staff knew the children's home circumstances well, and this related to a range of characteristics of the school. Most of the staff had been there for many years and they were all mothers themselves. The children and their parents became known to the staff during the nursery years. Also, the school was fairly small, so that staff could be familiar with all the children.

Understandings of Children at Home and School

As regards the children's home circumstances, the secretary, who had been there many years, reflected that formerly a few children came from poverty-stricken backgrounds but that now they were mostly well clothed and healthy. This change presumably reflected the recent gentrification of the area. According to staff, the children came from socially mixed families and, whilst there were some children whose well-being was thought to be at risk from family factors, in general the school's aim was not compensatory (as at North School), but based on a concept of advancing the welfare and progress of the whole child. Thus staff emphasized eliciting good work from the children and also caring for the physical and emotional side of the children. The presentation of the children's work in displays was part of the enterprise of promoting the children's sense of achievement.

The school worked on a child-centred model, reminiscent of the Plowden era, and perhaps was able to sustain this model more than all-age or junior schools may in the era of the National Curriculum. As noted earlier, this model aimed at promoting the best in the children on academic, physical and psychological fronts. The children were in this sense the objects of very carefully planned and organized adult input. They were also given considerable status as people with the capacity and wish to order aspects of their lives. Thus they were consulted in the planning of classroom displays and took part in putting these up. We heard that they had built a pond and regularly worked with a retired teacher on cultivating the gardens. They were asked to clean up, and tidy up after activities; and were encouraged to organize their own activities.

It was also clear from staff interviews that they regarded the children as vulnerable and in need of physical affection — we heard of children being hugged and comforted. This was very much an infant school, where the children's close ties with home and the care women give at home were recognized.

The Status of Children's Health at School

The children's health was high on the agenda of the school, and indeed the school worked within an overall concept of a whole child approach.

However, though the status of the children's health was high, it was evident that the school was finding it increasingly difficult to care for the children. The main factors have been outlined above: including, increases in class sizes; reductions in the quantity of the school health service input; inadequate resources to buy-in helpers for the classroom; and poor local community health and social services. The headteacher found it necessary to fight increasingly hard for resources.

Town School

Introduction: The School and Its Environment

Town School was an all-age primary school situated on an estate on the outskirts of a town in the Midlands. The estate was built in the 1970s and further development had taken place more recently — with consequent increase in the numbers of children to be accommodated in the school (from nine to fifteen classes). According to the headteacher, the school had a social mix, though very few children from professional families (e.g., doctors); children's parents were blue and white collar workers, including those in light industry and management jobs. Most mothers worked 'the minute their youngest child was in school', many in low paid, part-time jobs. Staff felt that family breakdown was increasing and that dealing with the children's response to this was also an increasing part of their work. Staff thought many parents were struggling financially, but were mostly at work and just over the levels of eligibility for benefits; 17 per cent of the children were eligible for free school meals.

The estate, sited near a ring road round the town, had its own playing field, and shopping complex within a quarter of a mile with a supermarket, fish and chip shop, stationers sweet shop and post office. The school was situated in a street of houses, and had a pedestrian crossing with lollipop lady. It was on a minibus route, with a frequent service. However the nearest health centre was in the town itself. Most of the children came from a half-mile radius, and lived in the owner-occupied and housing association small, semi-detached houses on the estate. The general effect was of a homogeneous, pleasant, leafy living environment. Children walked or cycled to school, and local roads had little traffic, but staff thought too many children were brought, unnecessarily, by car.

Like 20 per cent of survey schools, this one had over 300 children (339), but because the school was built for smaller numbers, it was now overcrowded. The children were divided into thirteen mixed-age classes (four reception/Year 1; two Year 2; four Years 3 and 4; three Years 5 and 6). Year 2 children were age-grouped because this was the SATs year. Staff were female, apart from the headteacher and a top class teacher. There were fourteen class teachers, two part-time special needs teachers. On the non-teaching side there were two administrative staff (a secretary and bursar), twelve non-teaching assistants and three caretakers. The staff–child ratio was 10.0.

Classes were large, with over thirty in many, but the SATs year classes were just under thirty. In the classes studied, there were twenty-seven in Year 2, and thirty-three in Year 6. The children in the school were almost all white, with one exception in each class studied. The impression of homogeneity was increased by the uniform — which most children wore.

By the time of our return visit, the prospects for the next academic year (1995–96) were for even larger classes with thirty-six in one of the top classes, and thirty-four to thirty-five in the junior classes. The school had planned to employ an extra top junior teacher, but budget constraints had intervened. However, 20 per cent of a teacher's time (she was currently employed part-time on special needs) would be available to help with top juniors. Other cuts had included a reduction in class helpers' time from 1.5 to 1 day a week for the younger children. In sum, this school exemplified the problem widely reported (e.g., *Guardian*, 25 October 1995): increasing numbers of children, and cut-backs on staffing.

The School as a Health-care System

School Buildings and Playspace

The main school building was built in the late 1960s in attractive brick and slate. The headteacher's and secretary's offices were in the main block by the entrance, with the staffroom on another corner. This part of the school was on a small scale and appeared cramped. The main classrooms were reached not through this section but through their own individual entrances.

Originally, there had been a space designated for health care, near the staffroom, but this had been taken over when the bursar post was established. So there was no first-aid room or SHS room, and children with illness or accident injuries were dealt with in classrooms and in the bursar's room; if waiting to be picked up, they sat in the entrance lobby. There was a lack of private space for children and parents to discuss issues with staff.

In the main building, classrooms, or class-spaces, were semi-open plan and were grouped in twos or threes, with a central resource area. These areas were semi-public and served as corridors to other parts of the school: children and adults walked across them. Children commented on the lack of privacy and the noise. The nine original classrooms were designed for no more than twenty-four children each; they were broadly triangular in shape, and this design was making it difficult to fit more tables in for the increasing numbers of children. Staff said there was a lot of unusable, wasted space.

Because of increasing numbers, six newer classrooms had been built. These were in three prefabricated blocks, each with two classrooms, built in the playground; one had its own toilet section. In addition, a toilet block had been built to serve these extra classrooms. These newer buildings had substantially reduced the amount of hard playspace available, and had also broken up the playspace into small areas, difficult to oversee, and dangerous for children's activity. There was also an older prefab on site, housing a playgroup, run with PPA (Pre-school Playgroup Association) support.

There was an attractive spacious open field with trees, hedges and stone walls round it. An adventure playground with a bark surface was used on a rota basis by all classes. In the winter and in wet weather the children were not allowed to play on the field. The infants and juniors shared the field, but there was an informal demarcation in the paved area. There was also a courtyard, with covered edges, sited in the middle of the main building. According to one teacher this has been designated as a quiet area — no running, and, in practice, it was mainly used by the infants, some of whom identified it as a preferred place at school. Staff planned to further improve playground life, through encouraging games, and also planned to improve facilities in the quiet area. This work was likely, because of cost and time constraints, to take place later, in 1996–97. However, work was in hand, funded by the LEA, for increasing the paved area during 1995–96.

In general, the school looked pleasant and fairly spacious but because it had been designed for smaller numbers, had inflexible classroom layout and now had larger numbers, staff and children felt overcrowded. The situation was due to worsen in 1995–96. Storing so many children's belongings — their coats, PE clothes and equipment, and their lunchboxes — was a problem, and more shelves and hooks were installed for the year 1995–96.

Staff commented that the younger children had plenty of space both indoors and out, but for all the children, toilets were too few and too small. Staff and the older children commented on overcrowding both in class and outside; in small playspaces children were inclined to fight and squabble. Teachers thought the children had to be over-controlled in class, because of the numbers, and that physical restriction was bad for their health. They thought this situation was exacerbated by current policy encouragement to keep children hard at work in class and reduce their time in physical exercise outside.

Among parents who returned the questionnaire (thirty-three of sixty-one, 54 per cent), the buildings and playspace attracted most of the adverse comments. They were concerned about the inadequate amount of outside space. Toilet and washing facilities were thought inadequate in quantity and hygiene.

Health Maintenance: Exercise

The school had a mid-morning break and dinner break, but no afternoon break — the school day ended early, at three o'clock. The PE coordinator (a senior member of staff) ran dinnertime and after school activities: dance, netball, football, cross-country running, tennis, cricket and athletics. A constraint was that there was only one hall. There was a school Brownie pack, run by the bursar.

Teachers thought physical exercise had high priority. In Year 2, the children did PE on four days and swimming on the fifth; in Year 6, they did PE

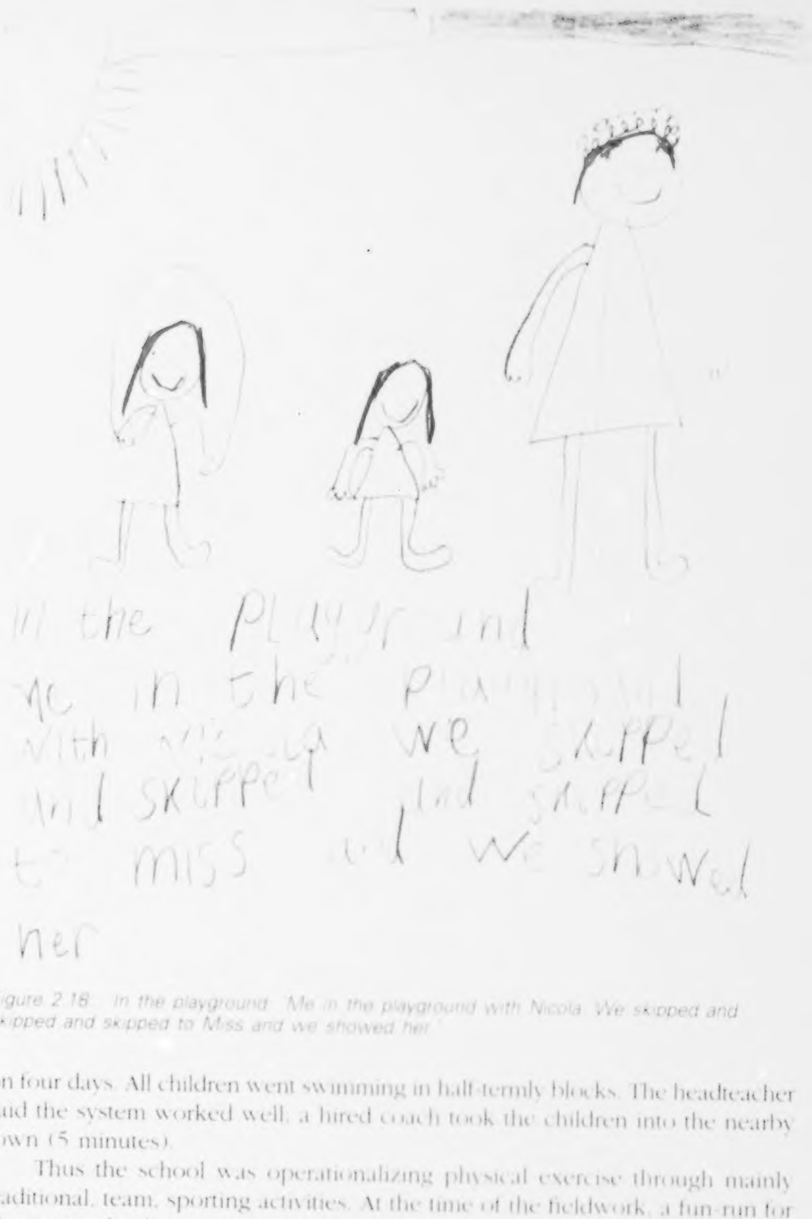

in the PLaygraund
me in the Playground
with Nicola we skippel
and skippel and skippel
to miss and we showel
her

Figure 2.18: 'In the playground: 'Me in the playground with Nicola. We skipped and skipped and skipped to Miss and we showed her.'

on four days. All children went swimming in half-termly blocks. The headteacher said the system worked well: a hired coach took the children into the nearby town (5 minutes).

Thus the school was operationalizing physical exercise through mainly traditional, team, sporting activities. At the time of the fieldwork, a fun-run for charity was leading to excited but mixed feelings in the children — enthusiasm and nervousness. Both younger and older children were appreciative of the opportunities for exercise, and, as at City School, the older ones especially welcomed their teacher's enthusiasm for PE and recognized its links with health: 'I like running 'cos you get really fit.'

Parents, as noted above, thought the outside space was inadequate for healthy exercise, although opportunities for play were thought good on the whole (play equipment, the adventure playground).

Health Care: Accident and Illness

Caring for children in the event of illness or accident was, in the first place, the class teacher's responsibility, as at Village School. A first-aid box was kept in each resource area. During breaks, the supervisors or teachers would bring the children in for first-aid. In more serious cases, the child was taken or went to the bursar's office. She had nurse training, and three other teachers had first-aid certificates, including the PE coordinator. The time the bursar gave to caring for the children was not recognized in her job remit — a common situation in primary schools. Some of the older children were aware that the school had formerly had a first-aid room, and commented that there should be one, where you could be cared for in privacy and where you could seek advice.

Observation suggested that accidents were rare — compared, for instance, to City School (a similar size school). Playground staff told us that children had to be taken inside for care at the rate of about one a week (compared to four or five a day at City). This presumably was in part a function of larger playspace, also perhaps of the fact that children were not allowed full-size footballs.

There were no written guidelines on the management of illness and accident. Records of accidents were kept only for the most serious — defined on an ad hoc basis. Only one had been recorded in the last three months (a child fell in the adventure playground — query, broken back — and was taken to hospital). Like other schools, this one emphasized parental responsibility for taking on caring work. A computerized list of parental and back-up contacts was thought to be effective in summoning parents to school. Most families lived and worked nearby. However, children were often to be seen sitting in the entrance hall, alone, waiting to be picked up. Staff stressed that they could keep an eye on them from the nearby administrative offices.

Staff commented that the informal lay health-care system was becoming difficult under the pressure from class sizes and the National Curriculum. Both they and children noted that it was difficult to balance the needs of the child against those of the class and the programme of work. As teachers said, each class also had several children with chronic conditions requiring extra care and concern: asthma, diabetes and eczema were mentioned.

A further issue of staff concern was the grey area surrounding the administration of medicines and treatments (plasters, cotton wool, antiseptic), where, as one teacher noted, regulations kept changing, and where staff had had to work through the limits of their remit. One example was where the teacher had agreed, after discussion with a parent, to administer drops regularly and antibiotics sometimes for a child with a hearing problem. Another was where a staff meeting had discussed whether a teacher should be willing to administer medical aid to a child to prevent an epileptic fit.

A mother took up the theme of the division of responsibility, in respect of asthma and recurring tonsillitis, and explained that the school emphasized children's own part in this responsibility:

> I asked the teacher and they obviously point out that they have a lot of duties to do during the day, and if they remember to give my child the antibiotic — they'll try to remember, but it's not really their responsibility to do that, and I do accept that . . . and the teachers actually tell her [daughter], remember to come and see me for your medicine, so. Yes, it's put on the child rather than the teacher

Health Maintenance: Food

School dinners were provided by LEA school meals service and were cooked on the premises in the school kitchen. Only a small proportion of the children had a school dinner (28 per cent: ninety-five of 337), and half of these were free dinners. A few children went home, but two-thirds brought a packed lunch and, according to the headteacher, this was because families tended to eat a main meal in the evening and because many families were just above the eligibility levels for free meals, and packed lunches were cheaper than the school dinner (£5.25 per week).

The meals were served in the school hall, in two sittings: children having school dinner and infants with packed lunch; followed by juniors with packed lunch. The children lined up and chose their food at a counter and sat at small tables. Three supervisors were on duty. The headteacher usually supervised the meal, and commented that though teachers used to sit with the children, and earn a fee for doing so, they were now so busy that they preferred a break or time to catch up on work.

On Wednesday there was a special dinner, with popular foods: hamburgers, fish and chips, chocolate cake. This had been introduced to increase uptake and maintain the service; it was favourably commented on by many children. In general, however, the LEA, under tendering arrangements, was battling with budget constraints and, according to one member of staff, the quality had deteriorated and 'proper meals' had given way to snack-like meals.

Staff also commented on the efforts kitchen staff were making to provide healthy food, and one teacher noted a problem caused by unhealthy packed lunches. To comment on them to the children would be to criticize parental behaviour, so this problem constrained her health education work on nutrition. Another teacher noted that she steered clear of any promotion of the school dinner — even though the school had a good nutrition policy. Under this, sweets and chocolate were prohibited and fruit only allowed. No foods were sold or provided.

As at Infant School, access to drinking water was a problem noted by parents. Parents objected to their children using drinking fountains, as unhygienic, and also said there were not enough places where children could get a drink.

Health Education and Health Promotion

The school had appointed a science teacher for the year 1994–95, with a remit to draft a health education policy, but she had left after one term. So, both science and health education policies were in abeyance, to be sorted out in the years 1995–97. However, there was a health education coordinator and a health education policy, according to which, health education was taught through cross-curricular topics, through science and opportunistically. It ran across all school years and there were block projects for each year group.

There was also a whole school policy to promote healthy behaviour in general, on nutrition, exercise, safety, personal health and dental care. Like other schools, this school was concerned about behaviour and had worked with the children during 1994–95 on a positive whole school behaviour policy (see below, p. 156).

It seemed that revision of the health education policy was on the back boiler, having given way to the urgent requirement to write other policies including special needs, and also because sex education had been found particularly problematic in the light of media coverage of a nurse (elsewhere) being reprimanded for explicit discussion. In practice, staff indicated that health education was being pushed aside by the National Curriculum but that it had been linked in with the science curriculum. The disadvantages of block projects were mentioned: children could conveniently forget what they were taught for the rest of the year. The only outside input to health education in the previous academic year was by the school nurse.

Further, the formal curriculum could be at variance with the informal. For example, the precepts of health education conflicted with the food children actually consumed both in school dinners and packed lunches. Another example related to hygiene. Teachers could not supervise a class and visits to the cloakrooms simultaneously: 'It's difficult to get them to wash their hands before dinner without standing over them'. Children also noted that the small numbers of toilets and washroom areas, sited some distance — outside — from the newer classrooms, were often dirty and unwelcoming places.

The School Health Service

As noted above, there was no designated space for the SHS. According to the school nurse, who had twenty-two schools on her list, the taking over of the

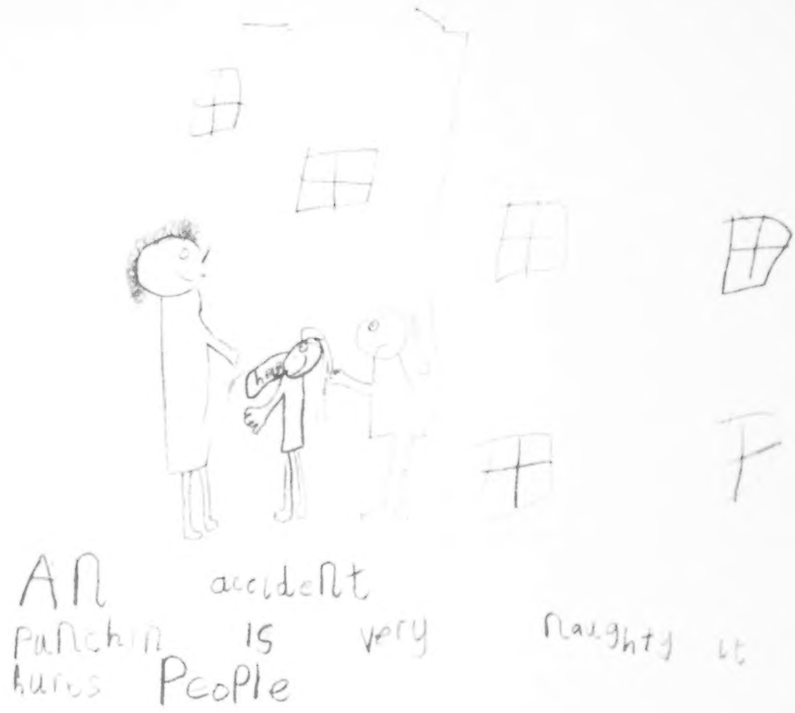


Figure 2.19 An accident. 'Punching is very naughty, it hurts people.'

SHS room for other purposes (administration, photocopying, computers) was common in schools, and only two of her schools had a first-aid/SHS room. The nurse argued that she needed a space too for private meetings with the children, so that they could talk freely to her.

The nurse visited rarely (two or three times a term), and worked wherever space could be found, on the day. She worked a 30-hour week, including travelling in a large rural area. The doctor and dentist visited once a term. In terms of visits per child by doctor and nurse, this school scored badly: they would have to see twenty-three children per visit in order to see all annually (see Table A2.4, p. 243), a number only exceeded at County.

In this area, children were given a pre-school check at the health clinic in the town before they entered the reception class. There was no established system whereby information would routinely pass from the health service to the school. The headteacher reported that no health information on school

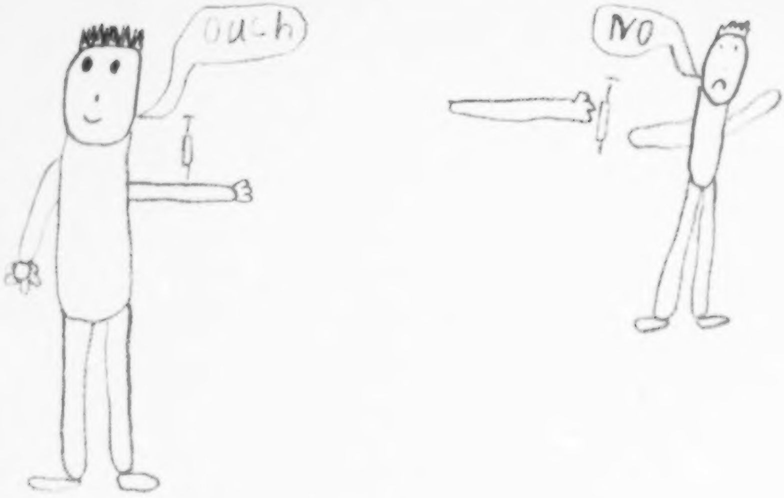


Figure 2.20: Healthy and unhealthy people

entrants accompanied them. He gave examples of older children joining the school, with severe health problems and no information, including a child with epilepsy.

The SHS offered consultations on request for children throughout the school, and sight and hearing checks for Year 6. Liaison between the SHS and the headteacher, teachers and parents was at informal levels only. The nurse showed the researcher a draft school nurse agreement to be drawn up by the headteacher and nurse on targets for health promotion, immunization, screening, selective health assessments, and drop-in self-referral, but this had not been hammered out by the time of our return visit.

The headteacher was concerned that the service was minimal and declining. Staff were faced with children about whose conditions they knew nothing. However, a diabetic nurse had come when asked for to advise a class teacher, and the headteacher said the doctor and nurse did follow up requests. The teachers, as in other schools, argued for whole class surveillance: 'You could miss problems with the current system of consultation on request.' One teacher quoted cases of children whose colour-blindness had not been identified for several years.

The headteacher noted an important disparity in health and social service provisions: the elaborate procedures for monitoring and liaison in respect of child abuse and the inadequacy of procedures to help children with physical conditions — for example, the school had received no guidelines on asthma. As he said, it seemed that psychological issues took precedence over physical problems.

Discussion

Provision and Intervention

Like Infant School, this one had an attractive building, designed within a Plowden-esque ideology of learning through activity and team-teaching, and on the basis of small class sizes (up to twenty-four). The resulting design of the classroom areas was experienced by teachers and children as unsuitable for larger numbers, and to delivering the National Curriculum. Children noted that there was no privacy and no boundaries between their class and others. The newer buildings in the playground were not architecturally distinctive, but provided roomy, pleasant classrooms.

Outside, the large field provided good space for physical activity and play, but usage was restricted in wet weather and the winter. The hard playspace was thought inadequate in size and difficult to supervise.

The school had intervened to modify the space provided: inside they had put in some curtains to separate teaching areas. Outside they had increased the paved area, but everyone agreed there should be more and it should be levelled. Plans were under consideration for extending the concrete area by taking up some of the grassed area. They had provided an adventure playground, which was very popular with the children. Markings on the playground and walls encouraged games. As at County School there was a designated quiet area — in the inner courtyard.

On our return visit we learned that, through the headteacher's initiative, staff, governors and children had worked on a whole school behaviour policy, in line with the recommendations of the Elton Report (DES, 1989), and using suggestions developed by Mosley (1993). This work included consideration of playground as well as-in-school behaviour. The children had worked on the development of classroom rules.

Linkages between physical provision, children's well-being and changing policies were well expressed by one teacher, in respect of cloakroom provision:

> . . . there aren't enough toilets and washing places. So, for instance, they all have to go at the same time, before lunch, and the cloakrooms are overcrowded, the pegs are too high, there is nowhere at the right level to put their packed lunchboxes, so there is always a hassle in the cloakroom . . . If you want to cut down on minor conflicts and children feeling bothered and unsettled, then these are important things to get right, you know, hooks at the right level, somewhere they can easily get their lunchbox, so they don't disturb other children trying to climb up and things like that.

Divisions of Labour

Unlike many schools, where the administrative staff take on the care of ill children and accidents, here, as at Village School, first-line care took place in class, where first-aid boxes were sited.

The bursar dealt with more serious cases. Class teachers experienced their responsibility as increasingly stressful, since it could conflict with the demands of large numbers of children and of the National Curriculum. However, as one teacher said, this arrangement was in tune with the concept of caring for the whole child:

> ... for our sort of primary ethos, you have the child in your care and you make all the decisions; the class teacher is responsible for the child, all the well-being, education and everything.

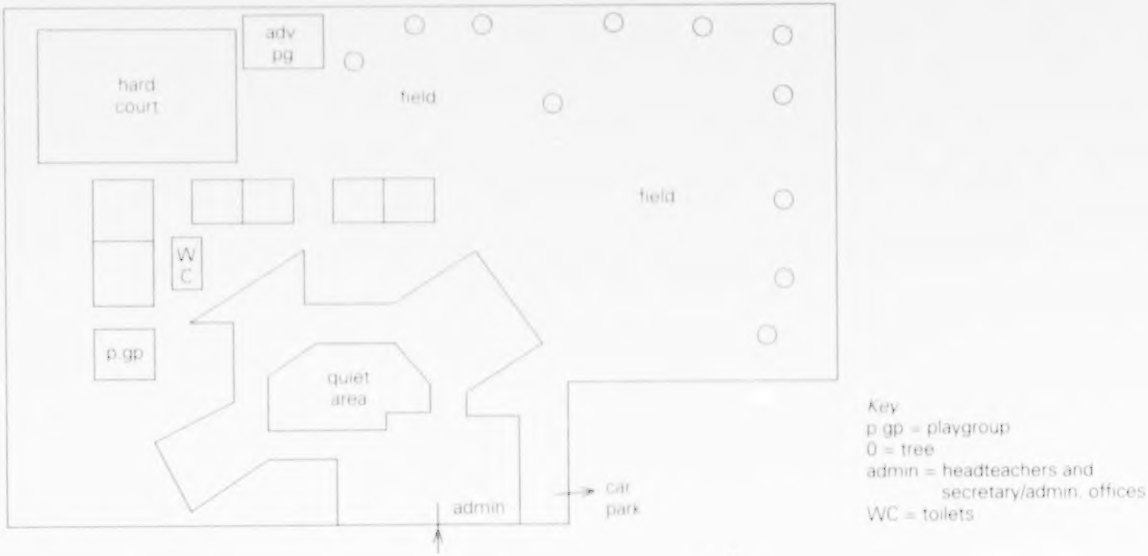
In line with the allocation of health care to class teachers, asthma inhalers were kept in the classrooms. According to children, school regarded them as responsible for bringing the inhaler to school, and for using it as and when needed (as the mother's comment above also noted; p. 152). So the inhalers were near at hand (in many schools they are kept in the secretary's room). The system allocated an extra job to the teacher, offered the children some control over their own medication, but required them to negotiate usage with their busy teacher.

As in other schools, this one demonstrated strains on the lay health-care system. Given the increasing numbers and demands on their time, teachers are finding themselves unable to give individual care to all children. Several teachers pointed to conflicts between their educational and 'social work' role. Children too noted difficulties here: they were not always listened to and cared for; their teachers displayed irritation arising from stress. As one teacher said, the classroom helpers have an important function in developing close relationships with children and enabling them to talk about concerns; a 20 minute conversation was cited where a boy 'poured out all his worries' to the helper.

School–Community Relationships

The school had a PTA, active in fundraising through many social events. School–parent contacts were initiated before children started in reception class, by a teacher visit to their homes. As one boy noted appreciatively, the increasing number of social events was making the school a more important and enjoyable place, one he was proud to belong to.

The school premises were used by several groups: Brownies, a playgroup and keep-fit group. Less welcome was the (unauthorized) use of the premises by local young people and dog-walkers, reported as leaving rubbish and dogs' mess around.


adv
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Key
p gp = playgroup
0 = tree
admin = headteachers and secretary/admin. offices
WC = toilets

Figure 2.17 Sketch map of Town School

Staff thought there were increasing social problems in families locally and that the school was increasingly taking on social work functions. As noted above, they thought this difficult in the context of increased workloads. One teacher remarked that at parents' evenings, 'I'd say 50 per cent of the parents end up talking about themselves and their problems.' Compared with City School, where poverty and acute social problems were regarded as a fact of life, here, in a more affluent area, staff lamented the breakdown of the family, dual career families and parental inability to meet their responsibilities. In the context of describing the time (an hour and a half) she had spent sorting out a bullying case with parents (of both victim and perpetrator), one teacher said:

> I think parents, the pressure of life, the stresses, the parents need more support, they can't cope with their children.

As to help in school from local people, parents helped mostly in the younger classes, thus four parents helped regularly in the younger class, and two in the older class (one as computer consultant to the children). The school had little input into health education from outsiders, with the nurse the main contributor. The headteacher thought the education social worker was not fulfilling her remit as a social worker, but seemed to concentrate on school attendance and suspension cases.

The school belonged to a partnership of fourteen primary and two secondary schools, and this was seen as very useful in maintaining links and discussing issues of common concern.

Understandings of Children at Home and School

Staff expressed the view that the former social stability in the area — middle England — was disintegrating, that this was wholly bad, and that children were the victims of this process. Family breakdown, stress on parents, stranger danger, traffic dangers, television, were cited as phenomena leading to increased physical and especially emotional risk for children. For staff, it seemed, these changes were insidious and cumulative; the implications were that they had to take on more of a social work role.

In complement to this point, staff indicated that children needed to be protected from knowledge. For instance, sex education and other health education programmes, developed for an urban and multi-ethnic population, were seen as not entirely appropriate for these children. Protection was important so that these children could live out their childhoods.

The Status of the Children's Health at School

It seems likely that the children as a group had fewer physical health problems than in some schools. But in the younger class there were children with diabetes (one), asthma and eczema (one), and in the older class children had asthma (about four), perforated ear-drum (one), sight problems and colour blindness (one), and heart murmur (one). And these conditions were dealt with by the class teacher on a day-to-day basis along with learning difficulties and minor illness and accident. The children themselves, especially in the older class, said they sometimes could not get their teacher's attention and care when they asked for help; he was often pre-occupied with looking after this class of thirty-three children, including two year-groups. For staff, who saw care and education as inseparable, conflicts between the two could be severe.

> There isn't time to do all the caring needed. Sometimes you have to put education first.

The school provided good curricular opportunities for physical exercise, perhaps less emphasis on health education. And, as in all the case-study schools, there were gaps between policies and practice (on meals, hygiene) resulting in part from factors (mainly budgetary) beyond their control. However, a health promotion initiative was working towards whole school behaviour improvements.

Staff regretted that the school lacked a space for children to rest, and, as one teacher noted, it also lacked clearly defined procedures for caring for ill children. Though the bursar offered care for serious cases, this was not part of her formal remit. It seemed the school's informal health-care system was not working as well it might in the face of increasing numbers and increasing demands on staff under government education initiatives. The lay health-care system probably worked better with smaller numbers.

The school health service was residual, and acted mainly as referral agency. Though the general standard of health may have been high in the school, the headteacher clearly thought the SHS input was inadequate. The organization of the surveillance system, with its pre-school inspection through the community health service, militated against adequate transfer of information through the SHS to the school.

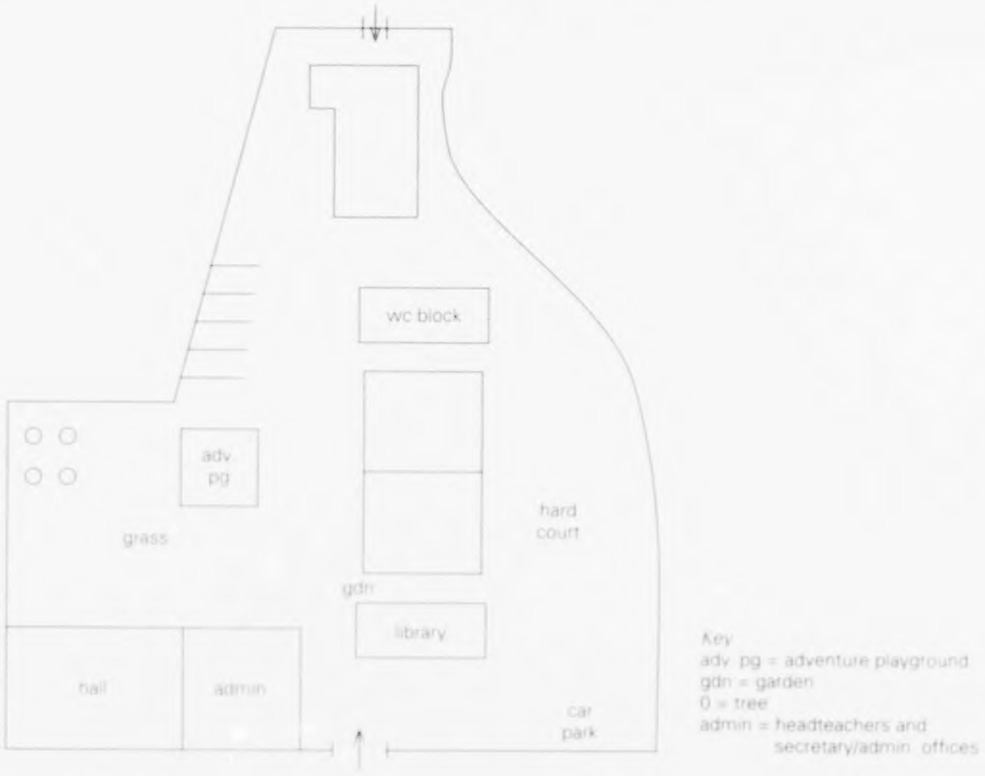
wc block
adv.
pg
grass
hard
court
gdn
library
hall
admin
car
park
Key
adv. pg = adventure playground
gdn = garden
0 = tree
admin = headteachers and
secretary/admin. offices

Figure 2.21 Sketch map of Village School

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Village School

Introduction: The School and Its Environment

Village School was a small all-age primary school sited in a village in a rural area of the Midlands. It had only four classes, and in this was like 9 per cent of our survey schools. The children came mostly from fairly well-to-do families, judging by the fact that only 9 per cent (ten of 104) were eligible for free school dinners. The village had two distinct ends: with a mix of council housing and cheaper modern homes at one end; and more expensive, picturesque old village houses at the other.

The school was situated in the middle of the village on a fairly quiet road, off the main through road. There was a narrow pavement outside the main gate, and no pedestrian crossing. There was also a back gate in a lane behind the school. The nearest shops to the school were a small supermarket and post office, five minutes' walk away.

Most of the children (82 per cent) lived in the village, with the rest coming in from villages two or more miles away, and a few travelling up to seven miles to school. Many of the children came to school on their own, walking or by bike, but some came by car. The road by the school was twisty and thought to be dangerous.

The school had 104 children aged 4–11, taught in four classes — Reception Class 1 (twenty-seven children aged 4–5), Class 2 (nineteen children aged 6–7), Class 3 (twenty-four children aged 8–9) and Class 4 (thirty-three children aged 9–11). The headteacher aimed to keep Class 2 small because this was the SATs year, and the class teacher also had responsibility for special needs. All the school staff were women and there were 4.5 teachers including the headteacher (who took Class 1 for half the week), a secretary (0.5), one non-teaching assistant, three supervisors and a caretaker. The staff–child ratio was 9:45.

In this school, the smallest of our six schools, the teachers and children knew each other well. And because of the awkward layout of the school, and the small number of adults, children were frequently sent, in pairs, with messages, a practice which increased familiarity. The researcher's impression was of an orderly, disciplined and friendly environment. The children seemed to be confident about approaching the teachers at all times (even in the staffroom at lunchtime — often discouraged in other schools). Children wore uniform, but with individual variations.

The School as a Health-care System

School Buildings and Playspace

The school was sited on a long rectangular plot stretching from a winding village street back to a lane, with an entrance gate at both ends. The original school building was an eighteenth-century, two-room building, fronting onto the street. So in national terms, the school was one of the 11 per cent of rural schools sited in pre-1875 buildings, in an old school house.

Behind the old school house was a toilet block, serving the whole school, beyond that a prefabricated block with two classrooms, a prefab housing the library and at the back of the site a further, brick-built block with a hall and the administration: the secretary, headteacher and a staffroom with cooking facilities. Classes 3 and 4 were in the old building and Classes 1 and 2 in the prefab block. In all, then, there were five buildings.

Given the number of separate buildings, the school had made arrangements to keep everyone in touch. There was a telephone in each classroom which rang to signal the divisions of the day, and for other routine and emergency contacts, including when a child needed help.

The playspace was very limited in size and scope — and rated very poor by the headteacher. There was a grassed patch with a playstructure on it and a hard sports surface area, which needed resurfacing. There was also a small

Figure 2.22 In the playground: the adventure play structure

garden which the children helped maintain. The children commented on the cramped playspace, which limited their activity and encouraged accidents. A local playing field was sometimes available for sports sessions during the summer months, but there were several competing uses for it.

For the children the physical environment was poor. The older children's classrooms in the old building were dark and rather gloomy, with their high ceilings and gothic-style windows. The classrooms used by the younger children were not very well equipped, having just a sink in one corner, rather than a wet art area as in more modern buildings. The headteacher reported that the rooms were warm and comfortable in winter, but often cold in spring and autumn when the heating was off. On the very hot day when we made our return visit, the rooms were stifling, even with blinds down, fans on and doors open.

The hall looked too small for the whole school assemblies held there, and for a class of up to thirty to do gym, and there was no large-scale equipment (unlike the other five schools). Teachers confirmed the drawbacks we observed. The library was too small for a whole class to spend time there. And all the children had to go outside to get to the rather bleak toilet block. Teachers said the toilet block presented a supervision problem, since they had to stay with their class while sending groups off to the toilet. Staff thought the provision was inadequate for the number of children, with two toilets, three urinals and five basins for the boys and three toilets and three basins for the girls. In winter, problems were compounded, since children had to put on coats to go out to the toilets.

This school undoubtedly needed a new building and plans for one were at least ten years old. The headteacher was doubtful if it would ever be built, given budgetary constraints; probably they would simply 'have to make do with what they had'. Five of the six parents who returned the questionnaire commented adversely on the building; as two of them tersely put it: 'Build a new school!'

For the year 1995–96, the school was planning to improve classroom facilities by decoration, and by getting rid of large bulky pieces of furniture. In both cases, success depended on funds and the headteacher rated the chances of the former low and of the latter medium. However, improvements to the playground would take place.

Health Maintenance: Exercise

The school day provided a mid-morning breaktime, an hour at dinnertime and, for Classes 1 and 2, an afternoon breaktime. The morning and afternoon breaks were supervised by the teachers on a rota basis. During the dinner break two supervisors covered the two main play areas, with a third overseeing the children while they ate in the hall. Generally the older children tended to use the hard playspace, with the boys using most of it at dinnertime for football.

The younger children played in the grassed area, with some mixing by sex, though there were groups of girls interrupted by boys. Classes were allowed by rota on the play structure.

The playspace for the children was inadequate in size, as the teachers agreed, although the new play structure set on a soft surface, was, as children and teachers noted, a great addition. Teachers reported 'a lot of hassles with ball games' and domination by the boys, children commonly tripped on the uneven surfaces, and it was also hard for the adults to supervise the different areas separated by buildings. The headteacher noted that providing a wider range of activity was a priority, for instance by painting games on the hard surface.

Formal curricular exercise was, we were told, 1.75 hours for Class 1; 2 hours for Class 2; and 2.5 hours for juniors. All the children went swimming, taken by minibus to the local secondary school (three miles away) and a local mother who was a trained swimming instructor taught the children. The time spent swimming was limited by the time taken to transfer the children by bus. Children also used the secondary school gym and sports fields for PE sessions. Sports and matches were organized out of school hours and children reported on these in the school's newsletter.

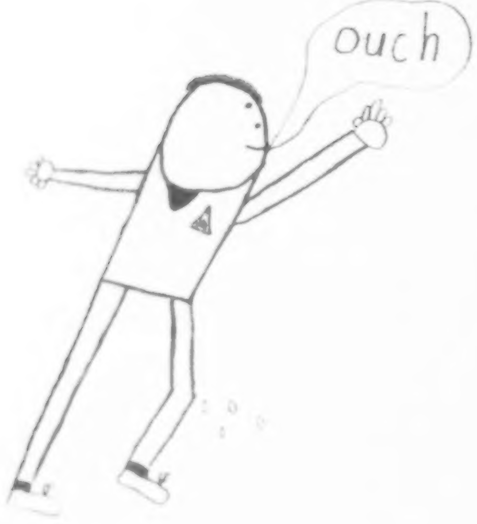
Opportunity for exercise was welcomed by almost all the children. In particular, almost all the younger ones described playtime as enjoyable. Sporting activities were widely appreciated by the older children, and mentioned in all but three of the sixteen paired interviews. But whilst most of the thirty-two older children referred in their topic work to exercise as one of the main healthy activities at school, two-thirds thought there was insufficient of it — 'there's too much work, work, work' — and they thought the playground was too small for sports. Many older children regretted that they had less time for play now; looking back to their early years, they thought the balance of work to play was better then:

> [It used to be] work in the morning, trying to write your name, and playing in the afternoon.

As in all schools, though staff were aware of bullying and aggression and stressed education in good interpersonal relationships, both opportunistically and more formally in health education PSE sessions, children experienced violence in the playground, with many younger, but fewer older, describing incidents and their fears. According to teachers, children, and our own observation, much of the problem concerned active, aggressive boys dominating quieter groups of girls.

Health Care: Accidents and Illness

The awkward physical layout of the school with its five separate blocks, as noted earlier, had led to provisions for contact between classrooms and also for independence within classrooms, with each having a phone and first-aid



An Accident

Some times people have Accidents. there are allSorts of Accidents and this is one. Becouse this is a picture of Some one falling over.

Figure 2.23 An accident: 'Sometimes people have accidents. There are all sorts of accidents and this is one. Because this is a picture of someone falling over.'

box. All four of the class teachers had done long first-aid training. The main first-aid equipment was in the library, and in some cases children were treated there and could lie down. As the head said, supervision was a problem: staff had to put their heads round the door to check that a child was alright. Again the small number of staff meant that getting cover for the class, if a child became ill and needed care and treatment, was problematic.

There were no guidelines for illness, but there were for accidents, which were entered into an incident book. Parents were always informed about accidents and at the teacher's discretion about illness. Both teachers and the few parents we consulted seemed satisfied with the system.

Unlike many schools, here the secretary was not the key dispenser of first-aid. As she said, she did not have first-aid training. But she did take an important role in comforting children, in keeping records of accidents, and in contacting parents.

So this small school exemplifies the traditional informal lay health-care system of primary schools, where all the women take part as required in caring for the children.

Health Maintenance: Food

This school, like 8 per cent of the survey schools, did not offer a school dinner. The factors leading to discontinuation were related to us by the headteacher. Meals used to be cooked on site (in what was now the staffroom). The cook had left, and it had been proposed that meals be brought in from another school; but only a third of the children were staying for dinner and simultaneous cutbacks in education budgets were biting deep. Parents were consulted and agreed to the idea of the packed lunch.

Because of limited space, the children ate their packed lunch, class by class, in the hall, each class having about 15 minutes. One mother commented that this was too short a time for her child, and some children agreed. However, staff thought children had plenty of time to eat.

There were no foods prohibited, apart from fizzy drinks and drinks in glass bottles. One problem was that there was nowhere suitable (cool and out of the way) to keep the lunchboxes during the day. So they were stacked up in each classroom. Teachers expressed concern about the quality of some of the food brought to school; some parents were thought to be ignorant or not sensible about food choice. One teacher also noted the difficulty of discussing appropriate foods with the children: adverse comment would reflect on parents. One of the three supervisors sat with the relays of childen during the packed lunch period; teaching staff had encouraged her to urge the children to eat the healthy foods they had brought and not just the sweet items.

The local education authority provided a free packed lunch for those eligible. This was brought to the school each morning, and the secretary repacked it in the lunchboxes provided by the ten children concerned, so that they would not stand out among the other children.

Milk was provided by the school, but paid for by parents. Thus what children consumed during the school day depended mainly on parental choice, rather than school policy and practice.

Most of the older children (thirty of thirty-two) asked in the topic work to note healthy and unhealthy activities at school, noted that consumption of sweets and/or sugar were unhealthy things they did at school. Fifteen children specifically referred to 'bad food' or a 'bad diet'. Though we did not ask the younger children these questions, we did ask them what they had in their

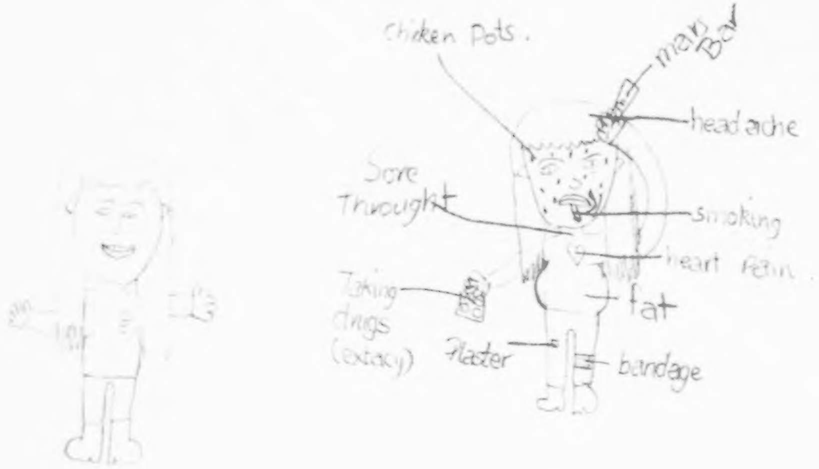


Figure 2.24 Healthy and unhealthy people

lunchbox that day. The main ingredients were: sandwich, chocolate bar, a drink, crisps, and, in seven of fourteen cases, a piece of fruit.

Health Education and Health Promotion

Given the small number of staff, responsibility for more than one part of the curriculum was carried by each teacher. Health education was coordinated by the teacher of the top class, who also took responsibility for PE in the school and argued for coordinated consideration of exercise, health education and science education. The headteacher thought that health education should be thought of in conjunction with PSE work, and that 'health awareness' had increased since this teacher had taken over the coordination.

Thus in practice, the school adopted a cross-curricular approach. Health education was conceptualized, as the coordinator said, in broad terms, covering scientific understanding of health issues, 'social training' and discussion of issues of concern to the children, such as behaviour in school, including bullying. In addition, as the teacher of the younger children said, health education took place opportunistically, as the occasion suggested.

The school was currently updating its policy on health education, and it used LEA guidelines, with written policies on health and safety. The school aimed to promote good personal relationships, with emphasis on discipline, and to promote healthy behaviours in exercise and hygiene. Nutrition was taught as a topic in Year 6 and sex education was planned for these children. Other topics were introduced as they arose during topic work. Smoking was banned in the school and sessions had been organized with parents to alert them to dangers from drugs.

The School Health Service

In common with all the case-study schools except City, this one had no specific space for the school health service (SHS). It functioned in the library or hall, depending on which was free. The nurse screened the reception class for height, weight, hearing and vision; and the doctor carried out a health check with Year 6 children. Otherwise consultations were by request. The school nurse usually visited four times a term, the doctor termly and the dentist yearly. In order to see each child annually, the nurse and doctor between them would have to see nine children on each visit (see Table A2.4, p. 243); so this school was in that respect relatively well served, along with Infant and City (compared to Town, County and North).

The school nurse reported — like all those in this study — that she had a very heavy caseload, including twelve primary and one secondary school, and considerable travelling over twenty square miles (thirty-two square kilometres). But, given the numbers of children, she was offering a higher rate of visits than most schools in our survey had. The nurse also took part in health education, doing sessions on smoking and asthma for the whole school, and on menstruation with Year 6. She told us she took part in the new parents' evening, where she was introduced to them and encouraged them to approach — 'but it rarely happens'. The headteacher rated the input from the SHS as very good in terms of both quality and quantity (like 15 per cent of survey respondents), and it seemed that this was mainly in appreciation of the nurse's work. Though in other schools staff reported they had little information about the management of chronic conditions, in this one the head had been successful in getting from the health authority guidelines on asthma and diabetes, and on healthy packed lunches.

According to the teachers, they had little contact with the SHS — as regards its medical functions — although the Class 4 teacher worked with the school nurse on health education projects.

As regards contact between the SHS and parents, the nurse and the headteacher agreed that SHS contact was mainly through the head and the secretary. Parents had little direct contact with the SHS, and did not see it as a service for them. Some commented that they tended to rely on their own GP and dentist rather than the SHS. Whilst one thought liaison was good, another thought information about nurse visits was poor. However, the secretary reported that the nurse readily made herself available to any parent wishing to talk with her.

Discussion

Provision and Intervention

The school was striking both physically and as a small school. The physical environment of the school was the poorest among our six schools, in terms of the layout, size and condition of the buildings, and the quantity and quality of the playspace.

It was a small school (almost within the 18 per cent of survey schools with fewer than 100 children). It seemed that the advantages of small size were: everybody knew each other; staff felt they cared well for the children on the basis of personal knowledge; and people locally found it easy to relate to the school. Some disadvantages were noted, however: the older children, we heard, tended to 'grow out of' the school, and to be disenchanted with it; it had poor resources for improving things, such as building up the library; it had been an easy target for ending school dinners.

The school had taken many steps to make the best of their school. The harnessing of local resources was important, especially for PE (at the local secondary school), and using parental help across a wide range of activities. The children and staff were linked up with local churches, the playgroup and an old people's home. Some of the children's work, for instance on environmental topics, spread out into the locality. Within the school, it seemed there had been a clear commitment to promoting disciplined behaviour and a widely conceptualized programme of health education.

Divisions of Labour

This school exemplifies the idea of the school where roles are blurred and adults carry out a range of tasks. Whereas in larger schools, such as North and County caring for illness and accident was allocated to certain members of staff, here all the staff took part. Although one of the teachers was the designated first-aider, all five of the teachers had first-aid training and carried out first aid — the presence of first-aid boxes and phones in each classroom symbolized this arrangement. There was also a duty rota for looking after children with accident or illness. Unusually, the secretary did not regard herself as the main person on this front; her role was to keep records and to contact parents. However, she clearly did take part in caring work — and reported several incidents where she had sat with children: 'It was just a case of cuddling her, sitting with her and holding her until Mum could come.' This was a school with an entirely female staff, all of them mothers, and the traditional ability of mothers to turn their hands to any job, and to many jobs simultaneously, came into play here.

School–Community Relationships

The school is also an exemplar of close school–community relationships. The existence of a 'community' locally enhanced the school's ability to build good school–community links. The school appeared to be closely integrated with the village institutions, and reached out to the village as well as drawing people in. The school was sited in the middle of the village (and 82 per cent of its children lived there). It had links with the local Methodist and Church of England churches: ministers took Friday assembly in school and the children celebrated special festivals and occasions in church.

According to staff, the school had no difficulty in involving parents in the work of the school. They reported considerable amounts of help from parents — in class, in running out-of-school clubs, and in accompanying classes on trips. The secretary indicated that goodwill towards the school resulted from the ability of a small neighbourhood school to develop close and friendly relationships with parents, and with the wider family networks.

Staff reported, and the school brochure confirmed, that the children themselves were encouraged to take part in developing links with the local community through visits to local industry, and through the school's membership of various local organizations, such as the Trust for Nature Conservation, and a local citizenship programme. One of the older children commented appreciatively that they spent time at the local playgroup and at an old people's home.

The impression we received of good informal parent–staff relationships was endorsed by parents (three) who reported that school was very open to parents, kept in touch and kept parents informed. They also thought staff were very good about liaising when children needed to be got home, including actually bringing the children home.

> If they want you to do anything they will come and ask you straight away, or if you've got anything to say you can just go and say it.

However, we also heard that familiarity between parents and staff could lead to poor appreciation of staff work. This is perhaps a function of a small school. One teacher told us that at a large school she had worked in more distant relationships had fostered supportive attitudes and behaviour from parents. Here, she explained, when teachers thought parents needed help with parenting, such help could be hard to offer in the context of informal, personal relationships.

Understandings of Children at Home and School

The school had introduced a number of measures that indicate and endorse their understandings of the children. The character of the twice-termly newsletter was a case in point: children's work was featured — prose, poetry and drawings; awards for good work, behaviour or attitude were recorded there; reports on sporting events were written by the children. The children were encouraged to think of themselves as part of the local community through participation in work, for instance, at the playgroup and old people's home and in celebrations at church. At a wider level, their environmental work encouraged them to think of people's responsibilities to the countryside.

Staff had written a booklet for parents of children about to start, which included many suggestions for good parenting to prepare children for school, including practical skills (dressing self), social skills (being responsible for tidying-up, being able to listen to a story, playing amicably with others), cognitive skills (memory, language, mathematics) and pre-reading and pre-writing skills. Parental responsibility for preparatory socialization was thus seen as major and wide-ranging. In complement, and as in many schools, some staff comments pointed to parental responsibility for problems children presented at school.

The Status of Children's Health in School

In this school, the restoration of children's health was the responsibility of all the staff, and the school was extremely well staffed — with all teachers having first-aid training. As in all our schools, staff seemed confident they could always reach a parent or other responsible person in case of need. In addition, the complex of health education — PE, PSE and science — seemed to be thought out as an interlinked package, which indicates a commitment to promoting the children's health. Judging by the examples we were given, the children themselves were regarded as important in promoting their own health and the social health of the community. At a service level, the school had relatively good input from the school nurse. All these features compensated for the poor physical conditions within which the children spent their days.

Part III

The View from the Children

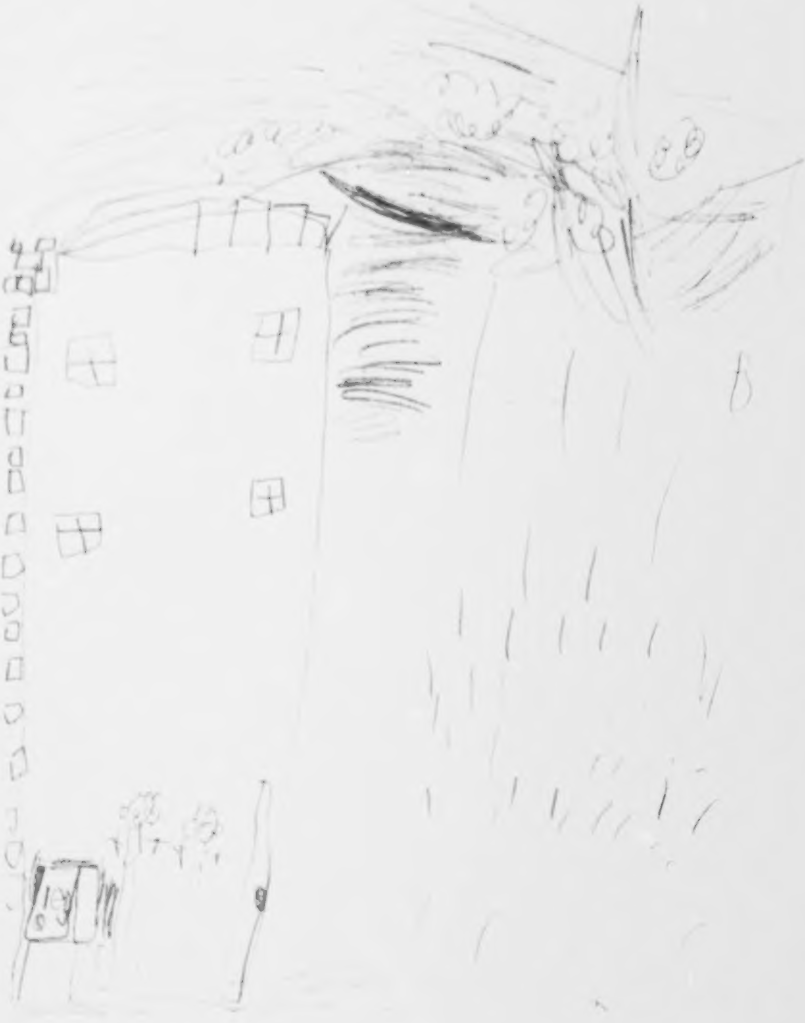


Figure 3.1. The school building

The View from the Children

Introduction

So far in this book, we have presented data about health-related features of primary schools through the eyes, mainly, of the adults closely concerned with children's daily lives at school: teaching and non-teaching staff and parents. We turn now to children's own accounts: their perspectives on the physical and social environment of school; on the school as a health-promoting environment; and on the school health-care system.

A reminder first of all about our informants. We collected data on health-related issues with a class of younger children — aged 6 or 7 — in five of the six schools (not North) and with a class of older children — aged 10 or 11 — in five schools (not Infant). In all there were 132 younger and 132 older children in these classes, 264 in all. The main data collection methods were interviews with almost all these (256 children) and written topic work with the younger children (117) and older children (95), in all 212 children. Further details about these samples, data collection methods and topics addressed are given in Appendix 4.

Collecting data with two age-groups across six schools presented a number of challenges and issues. We wanted to combine comparability with flexibility; we wanted to collect data systematically across schools, but we also wanted the children to tell us their views, rather than define the agenda for them. So we constructed outline interview schedules and topic lists to use with all children, but to allow them opportunities to develop ideas as they chose. We also encouraged children to make drawings of school experiences. We worked within the framework of the school day, in consultation with class teachers, and in some classes had more time allotted for the fieldwork than in others. It is also relevant that the work took place over two terms — the summer and autumn terms 1994: We used the methods and topics developed in an earlier study (Mayall, 1994a) as a basis for the work, but also developed new ideas as we went along. So between the first case-study at City to the last at Village, we incorporated some new topics to raise with children (e.g., If you didn't have to come to school, would you?).

The two main ways of collecting data were through written topic work and interviews. Apart from City, where the topics were covered informally during interviews, written topic work was carried out at all schools; during classtime, children were asked to write brief answers on factors leading to health, on responsibility for health, and on where health care takes place. These answers were coded and analysed by school, age and sex.

The interviews provided the fullest data. We chose to interview children in pairs, since this would allow them to discuss and develop topics with each other as well as with the adult researcher and would somewhat redress the power imbalance between adult and child. In all there were 117 pair interviews, six with three children and one with four children contributing (124 interviews in all). The pairs were mainly single sex, with pairings decided according to children's choice, or convenience. The main topics raised with children were: best and worst things about school; good and bad places and times in school; the story of a recent accident and illness; how school 'now' compared to school when younger. The interviews were coded and again analysed by school, age and sex. Because the interviews were joint efforts by the children, we have analysed most of the data by interview rather than by child.

The interviews varied very much in character. In some cases the interviewer felt constrained to work as fast as possible, in others there was a more leisurely atmosphere. Some children began by answering monosyllabically, but then relaxed and began to discuss the issues behind the questions. Some children used the interview as an opportunity to voice their fears and enjoyment of aspects of school; some boys, who knew they carried a label as 'naughty' or 'disruptive', seemed to welcome the chance to talk about their experience of school in the light of these labels. In a few cases, one child would dominate the initial stages of the interview, and the quieter child would more gradually stake out a position and make her views known. The researcher sometimes had to encourage children to move away from telling her what they thought she wanted to know; thus, in answer to the question, 'What is the best thing about school?', most children initially spoke about the formal curriculum, but when told we meant anything about school, began to talk about playtime, or hometime. Whilst in many studies, researchers find tension between their own agenda and those of their respondents, in this one we sometimes had to explain that we really did want to know about their agenda: what they thought, felt and experienced at school; and had to encourage these well-schooled children to talk with us about their own experiences of and understandings of school. A notable example here is the toilets: no child spontaneously talked about their merits or demerits, but when prompted many had a lot to say.

This chapter draws on the various kinds of data collected to provide a commentary on the topics covered in the six case-study chapters. The order of topics is broadly as in those chapters, but the arrangement takes account of how the children constructed experience. Children's talk about the **buildings and playspace** linked the physical with the social and emotional — playgrounds were physical places interpeted through the experience of social interaction. Similarly, children's understanding of the **school as a health-promoting environment** took account of the social experience of exercise and food consumption. In the section on **health care**, we have used their recounted experiences of recent illness and accident to consider how children understand and value the lay health-care system of the school.

The Physical and Social Environment of the School

Buildings and Playspace

We noted in Part One that respondents to the questionnaire gave mixed responses on the quality of the physical environment as a context for the maintenance of children's health. The building itself and the toilets attracted the highest proportion of poor ratings, and older schools got the fewest good ratings and the most poor ratings. Similarly, respondents' ratings of playgrounds and playground equipment as poor relate to the age of the school.

The six case-studies provide more detailed and complex data on these points. Two of the schools were pre-twentieth century: Village had an eighteenth-century building with modern additions, including an outside toilet block; City was a late nineteenth-century building, with outside and inside toilets. North was an early twentieth-century building, with integral, recently refurbished toilets. Town and County both dated from the 1960s, but, according to staff, County was poorly built and had worn badly, whereas Town was well built and had worn well, though a new classroom block and outside toilet block had been built to serve increasing numbers. Infant was newer, a 1970s building, purpose-built for its current use. Comments from the children show some similarities with, and some differences from, those of adults. Like the staff, children were pragmatic: they accepted the physical environment as the place they had to live in and come to terms with, and also praised recent improvements. The recent refurbishment of toilets at North and Village received praise from both adults and children.

Many children at City and North recalled how the size and complexity of the building worried them at first. Thus, children agreed with staff at North that the building was daunting.

> *Boy 1*: At first it were a bit of a shock 'cos it were so big. And someone told us there were ghosts coming out of the toilets and we believed it. And people with NafNaf tops on beat you up.
> *Boy 2*: X beat me up.
> *Boy 1*: Mrs A wouldn't stop telling us that the school is in a square and we'd never get lost, and this boy got told off because he said he couldn't find his classroom.

City children, too, faced with a very large building on several floors, each with somewhat similar layout, commented on getting lost and on getting knocked over by others in the headlong rush to the playground down the flights of stone steps.

County children made virtually no comments on the building. They had fairly spacious accommodation especially in linking areas and resource areas; it would seem that their social experience was pleasant but unremarkable in school. Town children spent their days in an open plan school, with class bays, shared resource areas which linked up to form an informal corridor running round the school. The older children reflected on ways the design affected their experience — there were good size, well-equipped spaces for project work and reading; but there was poor privacy. Notably, Infant School children made the most favourable comments. They worked in a building designed for its present use and where improving the physical environment further had high priority.

Being with a large number of children all day was a source of discomfort for some children and, given increasing class sizes, frank overcrowding was an issue. Judging by teacher and children comments, overcrowding inside the building was worst at Town. Children, like teachers, commented on the cramped working space in the class bays (designed for up to twenty-four children, but now having to accommodate over thirty): 'There's too many classrooms too close by each other . . . there's not enough room for everybody.' Comments on the implications of having only a small assembly/dinner room came from Village:

> The assembly room's really cramped . . . we only get 15 minutes to eat our lunch [i.e., because 100 children have to eat in four batches during one hour].

Linkages between the physical and the social were clear in the children's comments on the toilets: both boys and girls noted that boys left the toilets in disgusting condition; there were, in some cases, not enough toilets, and there was no privacy:

> Some people do their poo everywhere; there's four toilets, but sometimes two or three have poo in them.
>
> There's no privacy — sometimes they step on the toilet seat and look at the other person.

Both boys and girls commented on the desirability of separate boys' and girls' toilets, and both sexes noted that boys tended to use the girls' because they were cleaner.

Some children in all schools talked about their own classroom as a preferred place; it was safe and provided lots of interesting activities, books, toys, computers, large-scale construction kits, as well as some interesting work. 'It's a nice place to be and safe — strangers won't take us away.' Some said they disliked noisy areas and preferred quiet ones, such as the library, and these comments were especially common at North, where the corridor running right round the school, and the lofty echoing classrooms encouraged high noise levels. Some also clearly preferred the inside spaces of school to the outside ones; this was especially marked at City and North, where the playgrounds were perhaps the least attractive, being basically hard surfaces. At the other schools, over half the children, rising to over three-quarters at Town and Village, voted for outside space as the best place at school — playground, grassed areas and/or the adventure playground. There were no clear sex or age differences, although fewer boys voted for inside space than girls (45 per cent compared to 61 per cent), a point confirmed in many boys' expressed enthusiasm for playtime.

As indicated in the case-study chapters, all schools had taken action to modify the playspace. All had demarcated space according to age, and those with adventure playgrounds/structures operated class rotas. In addition, County, Town and Infant had designated quiet areas, and the children's comments show how valuable these were.

Children interpreted outside playspace through the social order of playtime — at break or at dinnertime. Here, again, children noted good and bad physical features of the playspace and how the social order intersected with these. For instance, Village offered the most cramped playspace, with an awkward layout, as the children noted:

> I don't like the big ones coming down the ramp, because they can knock you over, and I don't like people pushing me off the steps and stuff and I don't like people who are bigger than me pushing me. (Younger boy, Village)

Children recognized the necessity for rules about use of playspace, but felt constrained:

> ... we're not allowed to go places where the little ones can. If you want to go on the pitch [a hard court] and play around, you're not allowed to run really fast. (Older boy, Village)

> *Boy 1*: The adventure playground's good, but you're not allowed to play on that really, because we've not got enough dinner ladies to go round. *Boy 2*: So we can't play on it, and the field — in winter and that back corner. (Older boys, Town)

> There's only one playground you can play in and that's not that big and when you run, and there's lots of children there you could fall over; you bump into people. (Younger girl, City)

It is notable that many complaints on physical restriction come from boys, who are socialized to expect freedom of movement compared to girls (Young, 1980), who often use breaktime to chat to friends. It is also notable that children perceive the need to be on their guard in the playground against danger from too many people moving around fast. Both girls and boys appreciated the provision of quiet areas — 'where you can just walk around' — where running was forbidden, the risk of being hurt was much reduced, and you could retreat from and recover from bad experiences, such as unfriendliness or outright bullying.

The schools with the most spacious playspace, County and Infant, attracted correspondingly high rates of praise for playtime, compared to the other schools. Both schools offered both hard ground and grass areas, as well as gardens. County also had much appreciated quiet areas and at Infant staff organized games at playtime — which may have facilitated good social relationships between children.

At issue in children's comments on playtime are friendships, opportunities to play, violence, bullying and the threat of accident. Also relevant is the relative merit of playtime compared to PE sessions (see p. 190). Thus, at City, where PE had high status, but where the physical playspace was poor and there were many comments on violence and bullying, the interviews suggest that children valued PE more highly than playtime. At Town school, children commonly expressed dissatisfaction with the cramped playspace, and the fact that the field was out of bounds in winter and wet weather. At all the schools with adventure playgrounds — City, Town, Village and County — many children expressed pleasure and excitement about these, but were frustrated by restriction on use — generally by classes on a rota.

> *Boy 1*: I don't like parts where there's too much noise . . . At playtime there's too much running and shouting . . .
> *I*: Where do you like best to be?
> *Boy 1*: When it's lovely and quiet. On the grass and the path and the adventure playground.
> *Boy 2*: On the grass and the adventure playground and on the big field.
> (Younger boys, Town)

The children's comments on the buildings and playspace identify interactions between structure and agency, between the physical space and the social engagement of children with it and within it. At City, when children are rushing down the stone steps at playtime, chatting in groups, with older children dominating younger, then people get knocked over, or trip up.

Table 3.1 provides a summary of some of the main points children made about the best and worst things about school. In addition to those listed here, they talked about aspects of the curriculum they enjoyed (in 85.5 per cent of interviews), and did not enjoy (in 48 per cent). Apart from the curriculum, playtime (including breaks and dinnertime) and PE were the two aspects of the day most frequently mentioned as the best thing about school. There was no sex difference here, but younger children especially mentioned playtime; for them it was an important time for making friends and playing, even though for a large minority (43 per cent) it was also a dangerous time when they might be bullied. The older children were most enthusiastic about PE, and talked

Table 3.1 Best and worst things about school, by interview (%)

	Best things		Worst things		No. of Interviews
	playtime*	PE	bullying	staff	
Interviewee					
Younger children	70	64	43	26	61
Older children	36	67	29	44.4	63
All children	53	65	35	35	124

* note: playtime includes breaks and dinnertime

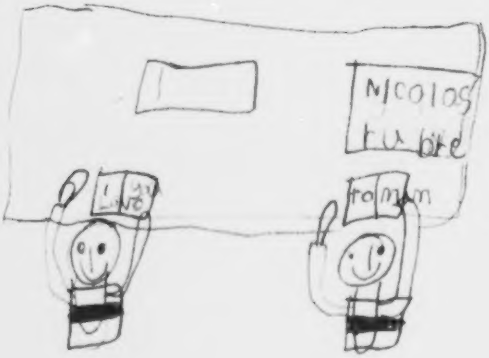
about achievement and enjoyment of formal games and sports; for them playtime was less important, for friendships and groupings were more firmly established already, and some were bored with enforced time spent outside with, in some cases, inadequate space for activity. As to the worst things about school, apart from particular 'subjects' they disliked or found hard, bullying — as a threat or actuality — and staff behaviour were the main problems mentioned. Child–child relationships and child–adult relationships are discussed next.

Social Relationships Between Children

Friendships and bullying emerge as the two major conflicting experiences of child–child relationships. As has been noted elsewhere, friendships, or at any rate companions, are not only pleasurable and rewarding, but essential at school, to spend playtime with and protect you against other children (e.g., Woods, 1983, p. 96; Mayall, 1994a, Chapter 3). Children recalled lack of friends during their early days at school as the worst part of their experience. By contrast, for most children, friends were now a major good thing about school.

> *Boy:* I felt scared [when first came to school] in case anybody came along and picked me up and threw me against the fence and I just felt so scared ... I was really shy, so I just went into Class 1 and everybody was horrible to me — said, Buzz off, would ya — and I just felt lonely.
> *I:* Is it better now?
> *Boy:* Yes, I've got billions of friends. (Younger boy, Village)

However, for a large minority of children, experience of school was damaged by bad relationships with children. In this study, since we could not investigate in great detail the precise character of events, we put together children's mentions of aggression, violence including name-calling and other persecution under the heading 'bullying': in 35.5 per cent of interviews bullying was described as one of the worst things about school, and this was higher among interviews with younger than older children (43 per cent and 29 per cent respectively), and higher in boys' interviews than girls' (41.5 per cent versus 27 per cent).



Me at SchooL
I Like it because
I Like doing writing
and I Like druwing
dnd I Like doing
Painting and
it is fun.

Figure 3.2. Me at school: "I like it because I like doing writing and I like drawing and I like doing painting and it is fun."

> *I:* What's the worst thing about school?
> *Girl:* Shouting and screaming and kicking people and biting. (Younger girl, Infant)

This girl tells us about interference in play, and ambiguities of interpretation:

> I don't like it when people like D and C put their foot in the skipping rope and make us go wrong . . . One time some boys came along and just when they was walking past they kicked me by accident. I don't like being kicked. (Younger girl, Infant)

And another girl clarifies what constitutes bullying and her feelings:

> *Girl:* Being picked on . . . children in our class, and other classes — boys.
> *I:* What do they do?
> *Girl:* Pick on you. Push me around, pull me.
> *I:* Have you told anyone?
> *Girl:* I once told Mr X . . . He's going to find out who it is . . . It's horrible.
> *I:* Are the teachers nice — do you feel you can go to them if there's a problem?
> *Girl:* Yes. (Older girl, North)

But it seemed that some girls managed to bypass bullying by forming their own groups of friends and seeing off people who interfered:

> I don't think I've ever been bullied . . . If E and F call me names, I know they're just playing, and I hold up a fist and they leg it. (Older girl, Town)

No school was exempt from accounts of bullying, even though, as we described in the case-study chapters, school staff were concerned and had implemented a range of schemes to tackle this widely recognized problem, including sessions on behaviour, codes of conduct and procedures for tackling bullying. In addition, schools attempted to monitor behaviour in the playground and had included both teaching and non-teaching staff in discussions and training on dealing with antisocial behaviour. Where there was a clear procedure in which the children participated, as at North and Town, children knew what to do and were confident that staff would take action. Even so, however, the system was not consistent in practice or entirely reassuring.

> *I:* If anything like bullying happened, who would you go to?
> *Boy 1:* I'd go straight to Mrs X (head supervisor), because she's the one that really tells them off. And now we have this new procedure — we have this book with how many times you've been really naughty and then you have to go to Mr X (the headteacher).

> *Boy 2*: But some of the dinner ladies, they don't do nothing. They say, 'Oh, go on playing!' and you get even more bullied . . . The dinner ladies, they just don't want to know.
> *I*: Is that all of them? Do they have a lot of children to keep an eye on?
> *Boy 1*: Yes, we need more.
> *Boy 2*: Really, the dinner ladies, they need to be more strict. Mrs X should learn them to be more strict. They just go, 'Keep away from him', but you can't because they just follow you. (Older boys, Town)

The lowest proportions of complaints in the interviews with children were at County and Village (24 per cent in each). In the other four schools the range was 38 per cent to 50 per cent. Of course we cannot definitively account for these differences. County had only older children, and had much the most spacious playspace, so children could spread out; it also had demarcated quiet areas for each year-group. Village, on the other hand, had very cramped playspace, but it was a very small school where all children and all staff knew each other, so perhaps socially acceptable behaviour may have been more firmly sanctioned by relationships outside as well as inside school, and monitoring behaviour may have been relatively easy. By contrast, other schools had specific problems. Notably, City children told us of racist name-calling, and of problems arising from aggressive play in a small space. Town had limited and awkwardly arranged playspace, difficult to monitor. At North, supervisors told us of animosity between themselves and the children, and their difficulties in dealing with aggression. The children's fear of violence, aggression and bullying provides one explanation why fairly low proportions of children (53 per cent) overall valued playtime as a component of their day (see Table 3.1, p. 181).

> The worst thing is when we're playing a game and someone's being bad to you and keeps on punching and kicking . . . (Younger boy, City)

Children's Social Relationships with Staff

Relationships with adults can also make or mar children's school days. Staff as carers in case of illness or accident are discussed later in this chapter (p. 197). Here we note some complementary points.

As the children indicate above, non-teaching staff as well as teachers are important in enabling children to lead positive lives at school. A major problem, given the status of non-teaching staff, is how to integrate them as part of the staff in policy-making and practice (cf. Sharp, 1994). Inequalities in pay, training and conditions of work are formidable barriers to such integration, however much desired by teachers and/or non-teachers.

Altogether, children in 58 per cent of interviews talked about non-teaching staff, with 31 per cent making positive comments — these were mainly that they were helpful, caring and supportive. Negative comments (in 16 per cent of interviews) related to the women not listening and responding, and making unfair judgments. In 11 per cent of interviews, children mentioned non-teaching staff without giving a qualifying comment. It would seem that non-teachers are more significant positively for younger children and for girls. Younger children interviews contained twice as many positive mentions as older (42 per cent compared to 21 per cent); this may be because some younger children sought and got help from them. Girls' interviews included more positive mentions than boys' (40 per cent compared to 22 per cent); this may be because boys were more likely to be involved in violence and to get blamed, they thought unjustly.

Several comments indicated children's understanding of the difficulties of the supervisors' work, for instance:

> *I*: Are they usually kind to you?
> *Boy*: They're usually kind, but usually not kind. They shout! They shout because there's lots of noise in the dinner hall. (Younger boy, City)

But others thought the supervisors were unfair in their judgments and reactions:

> I look forward to playtime, but some of the helpers outside are not very fair. If somebody said you did something, then they come down on you straight away. (Older boy, City)

As was noted earlier, most children said they found some aspect of the formal curriculum enjoyable, but on the whole they expressed this in terms of the subject rather than their relationship with their teacher. However, children's reflections on the quality of school now compared to when they were younger did include comments on teachers. Teachers merited 20 per cent of positive mentions and 40 per cent of negative. The main positive comments were about caring and good teaching; the negative comments related mainly to children's dislike of being told off and not being listened to. Slightly more of the older children made negative comments (22 per cent compared to 16 per cent from younger children) and slightly more of the boys (23 per cent compared to 17 per cent from girls).

For children the enterprise of learning is structured at school through the type and extent of teacher control; there is likely to be more discipline in larger classes, and more control over activity in classes of older children, where requirements on teachers through the National Curriculum may take precedence over children's control over learning. Children generally observed that school exercised more control over daily life as you got older, and that teachers demanded more work and allowed less play. Though children in almost all interviews (85 per cent) enjoyed some aspect of the curriculum, they rated playtime as the best time of the day in 50 per cent of interviews compared to classroom time (27 per cent of interviews); and in a quarter of the older children interviews, they noted that they had less playtime and less freedom now than when they were younger (24 per cent of older and 13 per cent of younger).

However, opinions varied widely on their enjoyment of the curriculum, and there are no easy summaries to be made. Here is a sample of comments, made in response to the question whether school was better now, or worse, compared to when you were younger.

> [School's] better now, because you do harder work and I like doing maths and writing. And being the eldest, so people can't hardly bully you. (Older girl, North)
>
> It's better now, 'cos we're going up to big school, and we get homework and it's harder work. (Older boy, North)
>
> Sometimes I get things wrong and the teacher gets angry and I get upset. (Older boy, County)
>
> I don't think the others would say this, but I think working is the best. 'Cos, I think, we only started school about a minute ago when it's nearly hometime. Because I look at my work, I don't think about the time. (Younger girl, County)
>
> I like school now because we've got a nice teacher — she's more kindly than Mrs X. Because when you're in class she gives you everything to do, but she doesn't shout as loud. (Younger girl, Infant)
>
> School was better then, because the teachers were looking after me. (Younger girl, Village)
>
> It was better then [when younger] because it was easier work, play all the time and you got more stories. (Older boy, Village)
>
> I prefer it now because I'm actually having to think a lot more and so [I'm doing] harder things which I didn't know about. (Older boy, Village)
>
> I like X's class, 'cos she lets us do choosing. (Younger girl, City)
>
> It's more fun now . . . we're doing a lot on health, about the body and periods. (Older girl, City)

Health Promotion and Health Maintenance

The children's comments have pointed to some important issues in their daily lives at school. They note the extent to which their well-being is enhanced or damaged through the physical and social environment, for instance they report noise, overcrowding and violence as adverse features, whereas they welcome

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and enjoy some aspects of work and time and space to play in. An important theme is how far can they control the factors that lead to their well-being, such as harmonious relations with other children and with adults. In this section we go on to consider other features of the school which may or may not enable children to maintain their well-being at school. We start with a brief note on formal health education and then consider children's understandings of their responsibility for their own health maintenance. We focus on children's views on physical exercise and nutrition as features of the school day.

Health Education

Our questionnaire showed that health education is generally carried out with younger children across the curriculum and so they may not identify it as a separate topic. In the case-studies, younger children did not talk about health education as a feature in their school days. As noted below (p. 192), where the teacher had explicitly linked physical exercise sessions with discussion of health benefits, older children's high evaluation of PE included comments on health benefits.

We know from the children's talk and writing, as well as from staff, that the main health education topics covered were diet, exercise and the body. There was particular enthusiasm from older girls at City about the sex education sessions. It was clear that gender was important in the children's reception of these sessions. The boys did not talk about them, and the girls argued that the boys were immature and failed to derive any benefit from information and discussion about sex and growing up.

> *Girl 1*: Yeah, we did a project on the body a few weeks ago. He gave it to us, and said, Make a project on the body.
> *I*: Was that all of you?
> *Girl 1*: Only the girls, because the boys were just too silly to do it.
> *Girl 2*: The boys keep taking the mickey, and the teacher tells them off.
> (Older girls, City)

Responsibility for Health Care

In an earlier study, on which this one builds, children indicated that, in collaboration with their mothers, they took considerable responsibility for their own health care at home, and by the age of 9, some argued that they themselves were responsible. However, children found the school required them to subordinate their health maintenance to the social and educational demands of the regime (Mayall, 1994a, especially Chapter 3). In this study, we followed up this point through the topic work, by asking children to note down whose job it was to keep them healthy, and what healthy and unhealthy things they did at school. (See Appendix 4 for details.)

This topic work was done during classtime, with the children each filling in a sheet of answers. No doubt the answers depended partly on their own understandings and experience, partly on what topics had been discussed among themselves or with staff recently, and somewhat, variably, on what their neighbour wrote. We report here the main findings; but not school differences since they may not be reliable. The principal point is that there was considerable common ground across age-groups and across all six schools. Apart from the answers we refer to here, there were very few other answers. It seems the children shared ideas and experience about who is responsible and what factors impinge on health status.

On responsibility for keeping them healthy (see Table 3.2), some children noted only one person, but many more than one, and the answers overwhelmingly pointed to the family, including parents and children, as the people responsible for keeping children healthy. Thus 56 per cent of all children noted parents or other family members as responsible, with mothers as the most commonly mentioned person; 47 per cent noted that they themselves were responsible. Older children were much more likely to identify themselves, compared to younger (73 per cent versus 22 per cent), and 30 per cent of all children claimed sole responsibility for their own health care (44 per cent older compared to 17 per cent younger). There were no gender differences as regards parents or self as health carers. Two-fifths (41 per cent) cited one or more health professionals as responsible. And only 7 per cent — all older children — cited teachers, the cook or the school as health carers.

Table 3.2 Whose job is it to keep you healthy? Percentage of children mentioning certain people

Children	*People mentioned*					
	family	family + self	self	health professionals	school	N
younger	56	5	17	37	0	102
older	23	29	44	44	15	102
all	39	17	30	41	7	204

no reply/illegible reply = 5

Asked to note down factors that lead to health, virtually all children (98 per cent) mentioned aspects of diet, with the younger ones tending to identify fruit, vegetables and salad, whereas older ones tended to note 'good diet' or 'good food'. The second major factor was exercise, mentioned by 50 per cent, including 20 per cent of younger and 80 per cent of older children. There was no sex difference on any of this. However an additional suggestion — general body maintenance — was made by more boys (twenty-five) than girls (fifteen). The age-related pattern of identification of food and exercise as key factors are consistent with earlier findings (Williams, Wetton and Moon, 1989; Mayall, 1994a, Chapter 3).

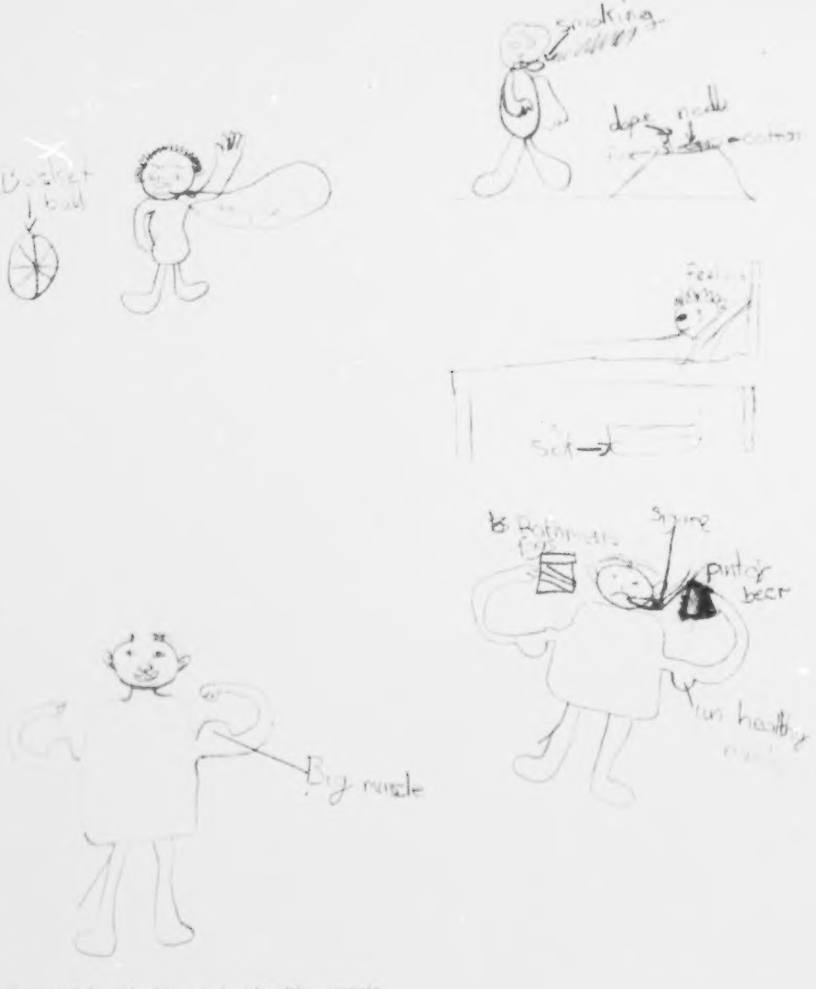
smoking
dope
needle
cotton
Basket ball
Feeling
Sick
B. Rothmans fags
Smoke
pint of beer
un healthy
Big muscle

Figure 3.3 Healthy and unhealthy people

We then asked children to note down what healthy things they did at school, and what unhealthy things (see Table 3.3).

Only a quarter (26 per cent) of children identified food at school as healthy, and most of these were referring to school dinners. Larger proportions (64 per cent) identified sugary foods, snack food and/or dinners as unhealthy features of the school day. More of the older children identified school food as unhealthy — 72 per cent, compared to 54 per cent of younger children (seventy-two of 100 versus forty-five of eighty-three).

Table 3.3 Healthy and unhealthy activities at school: Percentage of children mentioning certain topics

Topic	*healthy*	*unhealthy*
food	26	64
exercise	78	31
work	16	27
playtime	16	—
No. of children	198	183

> Bits of fat on the school dinners. (Older boy, Town)
>
> School dinners serve mostly chips and chocolate cake. (Older girl, County)

Large proportions of children (78 per cent) identified exercise — described as PE or sports or games — as a healthy feature of school and a further 16 per cent referred to playtime as healthy. But, especially among older children, there was some dissatisfaction that there was not enough exercise at school; 37 per cent of older children noted this, compared to 23 per cent of younger children.

> [Healthy] We jog, run, exercise, play sports and do PE.
>
> [But unhealthy] We sit down for most of the day doing work. (Older girl, Town)

Finally, the other main point they mentioned related to work, regarded by some as healthy — 'work keeps your brain moving and gives you knowledge' — and may keep your mind and body active; drama was commonly mentioned as healthy work. But again, in line with the point about inadequate exercise, some children (both younger and older) thought there was 'too much work'.

Thus it seems that whilst children identified good food and exercise as the most important health-promoting factors — though exercise figures more highly for older children — they also thought the school's main contribution to health was through opportunities for exercise rather than through the provision of good food. These points provide a framework for considering health maintenance at school, and the lay health-care system for illness and accident.

Physical Exercise in the Curriculum

Our survey showed that adult respondents generally gave high ratings to PE in their schools, with 71 per cent rating it good, 25 per cent average and only 4 per cent poor. It was notable that respondents in schools built before the twentieth century scored less highly; we assume this is because space available was poorer, assembly halls are rarer in the oldest schools (NUT, 1963) and outside space may be less appropriate in some cases.

As to the case-studies, we have reported above on the merits and demerits of playtime and shown, through a broad comparison, that children gave rather higher scores to PE (with its adult-controlled activities and achievements) than to playtime (with its uncertainties and dangers, both social and physical). We have also noted that some children in both age-groups, reflecting on their past school experience, thought they had less freedom now than previously (18.5 per cent of all; 13 per cent of younger and 24 per cent of older children).

The six schools agreed broadly on breaks for playtime: all schools had a morning and afternoon break for infants, but only a morning break for juniors. And all schools had a dinnertime play. As to PE in the curriculum, teachers expressed time allotted either in sessions or in hours; we heard that length of sessions might vary according to transport problems and other commitments (see Table 3.4).

Table 3.4 Weekly time/sessions for PE at six schools

City	
younger	2 sessions; 1.5 hours in all
older	5 sessions (varying lengths) plus swimming
County	
younger	2 sessions plus swimming
older	2 hours plus swimming 2–3 times a term
North	
older	2 sessions plus swimming
Infant	
younger	3 half hour sessions plus organized games at breaktimes
Town	
younger	4 sessions plus swimming
older	4 sessions (varying lengths)
Village	
younger	2 hours plus swimming
older	2.5 hours plus swimming

It would seem that all the six schools were offering, as part of the curriculum, more time to PE than the Dearing report recommended — one hour a week — and more than was found (one hour a week) in a 1993 study of time-use in inner London infant schools (Plewis and Veltman, 1995). However, there may be a difference between the stated time and the actual, experienced time. Still, it seems, by national standards, that the children in our schools perhaps experienced more PE than the average. At all schools, swimming involved bus transport to a pool; this was expensive and time consuming so schools rationed swimming and Infant School had decided against it. In addition, out-of-school sports activities, organized by staff and local volunteers were important especially for older children at City, County, Town and Village schools.

Sports, games, gym were highly appreciated by most children. In 65 per cent of interviews, PE was mentioned as one of the best things about school, and only fourteen children (of 256) thought it was one of the worst. There were no overall differences by sex or age in appreciation of PE.

Clearly, children's estimation of PE as part of the school day will relate not only to the quality of what is offered and experienced, but also to their view of the status of PE at school, and whether there is enough, by comparison with other activities in the day — other parts of the curriculum, assemblies, playtime. A daily short PE session and teacher enthusiasm may matter more than sheer quantity. What is on offer will relate also somewhat to the physical environment, and to the equipment available. Some of the teachers in our sample were especially keen on PE, talked with the children about its importance for fitness and health, and provided as much as they could fit in. Two of the older children's class teachers (Town and City) stressed that they aimed for the children to do some physical activity every day.

Children at Infant School scored highly for both PE and playtime. They had a very well equipped school, with a large hall/gym, and spacious grounds. We noted earlier, that though playtime is marred by fears of violence at all schools, fewer children at Infant School voiced these, but spoke of enjoying games such as skipping which were organized by staff during playtime.

City children, especially the older ones, spoke in the greatest detail about the importance of PE in their daily life. Here the teacher of the older class had instituted daily physical activity, with a linked emphasis on teaching its health-promoting functions. The work included both strenuous exercise and education on its effects on heart health and general fitness. Both boys and girls recognized the value of this linking of physical activity with learning.

> He makes us run all around the playground . . . down the road . . . [At first] I nearly fainted . . . it's really hard. But it's worth it . . . He tells us about healthy diet, and about too much fat in the body, and not having a healthy heart . . . When I first started in this class I used to be very chubby. (Older girl, City)

And a boy commented in relation to the daily PE, 'I didn't use to understand about the body, but I do now.'

At County, many of the older children [11 of 25] said the work was hard and they were required to work hard over long periods of time. Against this context, they enjoyed PE but felt their day was loaded towards work. The older children at Town also notably commented on pressure of work; for them an important factor was that in a large class, the teacher could not give them enough time each, and sometimes was irritable: 'With thirty-three, thirty-four kids, the teachers have to shout . . . but our teacher, he's probably one of the best in the school.' Most of the Town children talked about aspects of the work they enjoyed, and about half of them also expressed pleasure in PE sessions.

In summary, where children mentioned PE, they made positive comments; there were very few negative comments. (By contrast, playtime elicited both negative and positive comments, often from the same child.) They evaluated PE in terms of intrinsic enjoyment, but also in relation to other activities at school: it made a good change from sitting down in class. Children's knowledge of the relationship of PE to health status is evident in the topic work, and features in the comments of those whose teachers had explicitly made connections between the two.

Food at School

Children at school eat snacks, school dinner and/or packed lunches. Their control over these varies. Some schools allow only certain snacks and explicitly prohibit others. School dinner, as the questionnaire showed, tends to be provided without consulting the children — except in 11 per cent of cases — although they exercise some influence on future menus through the food they choose. Packed lunch contents are a matter of negotiation between children and mothers; some schools prohibit some items. In our case-study schools there was some variation on these points, as Table 3.5 shows.

Table 3.5 Food allowed, prohibited and provided at six schools

	Snacks	Dinners	Packed lunch
City	fruit/juice only	LEA, cooked on premises	no sweets, canned drinks, crisps
County	no sweets or crisps	catering firm, cooked on premises	no prohibition
North	no sweets or crisps	LEA, cooked on premises	no prohibition
Infant	no sticky drinks	LEA, cooked at adjacent school	no prohibition
Town	fruit only	LEA, cooked on premises	no prohibition
Village	no fizzy drinks or glass bottles	no school dinner	no fizzy drinks or glass bottles

At all six schools, supervisors oversaw the school dinner, although teachers at City, County, Town and North reported that a few teachers supervised too, and some ate with the children. In general, for the children, dinnertime is not an occasion when adults and children sit down together. Indeed, children may well think it is an occasion low on teachers' agenda. For some children it was crowded, noisy and rushed.

There is a clear disjunction between beliefs, knowledge and action here. Children, like the rest of us, believe that diet affects health. For most of the younger children, diet was the only factor mentioned as health promoting.

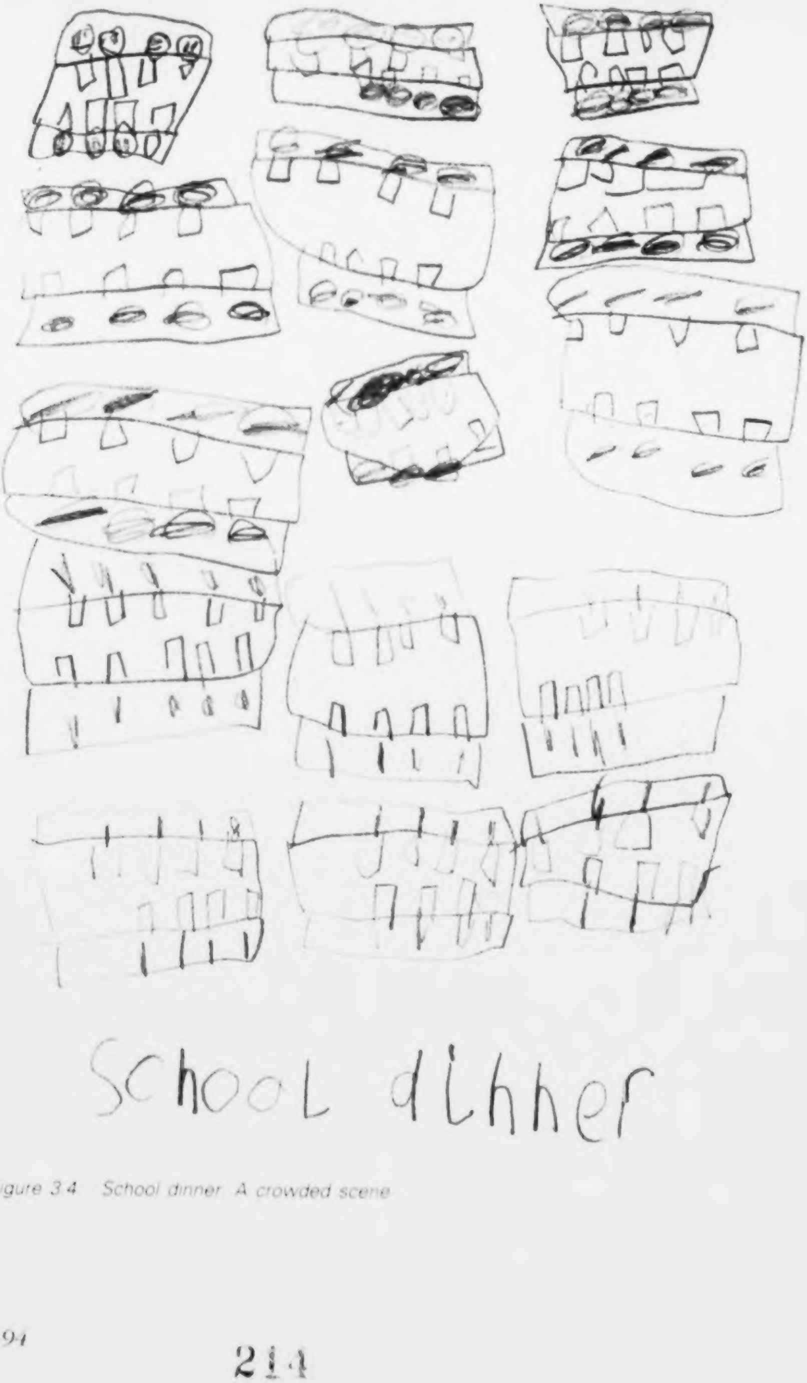
School dinner

Figure 3.4 School dinner: A crowded scene

They learn this first at home and then at school. But though teachers prohibit some sugary and fattening snacks, they do not control what is provided for dinners, nor, in the main, do they encourage healthy choices in dinners or packed lunches. Though some may wish to do so, the division of labour between catering and teaching staff, and time constraints, which encourage teachers to get a brief respite from the children at midday, ensure that children experience eating at dinnertime as remote from teachers' concern.

As noted above (p. 189) nearly two-thirds of the children (64 per cent) identified food as an unhealthy feature of the school day. In few interviews did children refer to dinners as a highlight of the day (thirty-eight children in all, or 15 per cent of 256). Some enjoyed the food: Town school's provision of favourite foods on Wednesdays found particular favour; and at North, the standard of meals was praised. Some City children noted especially that the cook would try to provide what they liked best. But some children found the noise, and being rushed, as unpleasant. The general impression children gave was that eating food at midday was not positively enjoyed; meals were a prelude or sequel to the more important long playtime.

Health Care: Accidents and Illness

Here we turn to children's own accounts of accidents and illness at school. Towards the end of the interview, we asked each child in turn to recall recent experiences (ideally 'this term') of being ill or poorly and of having an accident at school. This request led to animated and vivid stories of their experiences. Altogether children recalled 192 illness episodes and 156 accidents. In a few cases, one child reported two episodes and the other none.

Table 3.6 Percentage of illness and accident reports by type of interview

	Girls	*Interviews* Mixed	Boys
Reports of Illness			
younger children	76	85	58
older children	83	71	76
All children	79	79	68
Reports of Accident			
younger children	63	69	80
older children	74	53	69
All children	70	63	74

As Table 3.6 shows, more pairs of girls and mixed pairs than boys' pairs reported illnesses, and this difference was more marked in the older girls. This fits with the general finding that women report more ill-health than men (Blaxter, 1990, esp. Chapter 4); it looks as if the pattern starts early in life. Younger boys provided the highest percentage of accident reports, which resonates with our observation of gender differences in physical activity, rough-and-tumble play and aggression in playgrounds (cf. Smith, 1994). Most of the episodes were recent experiences but, where a child did not recall one, their accounts from the more distant past tended to be particularly dramatic episodes. In these cases, memorable features — vomit and gore — figured in the accounts, although many of the episodes were of relatively minor symptoms.

The three most common symptoms of illness were feeling and/or being sick (28 per cent), tummy ache (18 per cent) and headache (18 per cent); these made up 64 per cent of symptoms. The balance was made up of less defined descriptions (feeling poorly or unwell) and miscellaneous symptoms (sore throats, spontaneous nose bleeds, feeling dizzy).

The episodes described by children almost all concerned occasions when they had become ill at school; in only three episodes did they recount being sent to school with an existing condition. It is also notable that whilst we knew from class teachers that at least twenty-six children in our sample had chronic conditions (the most common being asthma), very few children mentioned their condition spontaneously or its management when asked about experiences of illness at school. So the stories concerned an acute onset at school, with its implications for the care of the child, by herself, and/or by others in the lay health-care system of the school.

We classified accidents according to the injured body part, although in many reports this was unclear — children mentioned a fall, or a cut, or a hurt. The most common sites mentioned were the leg (30 per cent of accident accounts), and the face or head (25 per cent); arm injuries were less common (8 per cent). These data are somewhat different from those collected in the questionnaire, which focused on more serious accidents; there 18 per cent of injuries were to the lower limb and 30 per cent to the head. The children's own accounts made it clear that their daily experience of accidents was more mundane, many reported scraped knees and minor cuts.

Although we asked for accounts of 'accidents', children's accounts indicate that in many cases the term is an umbrella for incidents with defined causes. Most of the accidents took place outside. As we have noted above, overcrowded playgrounds with fast-moving children and balls, bullying and attacks were features of the children's experience, and were strong themes in the accounts of accidents. Children referred to personal bodily contact or being hit by balls as the cause of the accident in 42 per cent of the stories, and described deliberate intention if not malice in half of these. For instance, in the sample of accidents recounted by the younger children at City, 62 per cent involved deliberate hurt and in the total sample a quarter of accounts contained an element of bullying.

> Once this boy came and splashed paint all over me and then he hurt me so I had a sore ankle. I went to the teacher on play duty . . . and she told me to sit down, and then I had to go to the office and they looked after me and wrote it all down. (Younger girl, County)

This example shows the lay health-referral system in operation at one school. The girl went first to the staff member on playground duty and was referred on. As we have described in the case-study chapters, schools had distinctive systems, though staff in all schools said that they coped between them, depending on the circumstances. At City and North, children were referred to the administration room where the first-aid box was kept. At County, a welfare assistant had been designated to provide care. At Infant, all staff took part. At Town and Village, first-aid boxes were kept in the classroom, with the teacher as first line of help. At Town, the bursar was the second stage. None of the schools had a sole-use room where children could rest, but had a range of make-shift arrangements for children to sit and recover or wait for a parent to come.

Table 3.7 Number of mentions of caregivers for illness and accident

School	*Caregivers for Illness*						
	Child	Teacher	Administrator/ Secretary	Non-teaching assistant	Welfare assistant	No. of mentions	No. of episodes
City	8	24	24	3	1	60	40
County	1	11	2	2	19	35	35
North	—	15	8	—	—	23	17
Infant	2	11	2	—	—	15	17
Town	4	30	5	6	—	45	42
Village	3	16	1	2	—	22	41
All	18	107	42	13	20	200	192
All %	9	53.5	21	6.5	10	100	

School	*Caregivers for Accident*						
	Child	Teacher	Administrator/ Secretary	Non-teaching assistant	Welfare assistant	No. of mentions	No. of episodes
City	6	8	15	7	—	36	28
County	2	3	1	2	10	18	28
North	1	1	3	2	—	7	11
Infant	1	9	—	2	—	12	19
Town	6	13	6	17	—	42	41
Village	3	11	—	2	—	16	29
All	19	45	25	32	10	131	156
All %	15	34	19	24	8	100	

Table 3.7 shows that during the process of help-seeking and help-giving, teachers were the most important group of people mumerically for both accident and illness. The administrators were particularly important at City and the welfare assistant at County. Non-teaching assistants were obviously more important for accidents, which mainly occurred at playtimes.

Children also acted as carers, both for illness and accidents. Some children did not seek help, but managed alone. Many recounted an episode where they demonstrated their own competence and independence and sometimes stoicism in the face of minor illness or trauma.

> We were running round, like — um I was sick in the toilets, but I didn't tell anyone. Nobody knew. (Younger boy, County)

> Well, I tripped up and I was in agony. I went along, going, pretending there was nothing wrong with me. I didn't go to Mrs X. (Younger boy, County)

> *I*: Did you tell anybody [about banged head]?
> *Boy*: No I keeped it a secret.
> *I*: Why did you do that?
> *Boy*: 'Cos I didn't want anybody to know I was a cry-baby.
> (Younger boy, Village)

So it seems that some children's response to being without their mother's care is not to rely on substitute adults, but to take responsibility themselves. Others first turned to another child, or a child might offer help and sometimes accompanied them to an adult for further care. Children thus offered practical help, advice and emotional support during the episode (cf. Christensen, 1993).

> He knocked me down on his bike, and I got my head split open. This girl picked me up and she took me to my teachers, and she took me to Mr X and he cleaned up my head. (Older boy, North)

> [On whether to seek help:] I feel like I could tell my friends, but sometimes I feel like I can't tell the teacher . . . it depends what kind of mood she's in, and sometimes I feel I can't tell her at all. (Older girl, Village)

We asked the children to evaluate the process and outcome of the illness episode and accident by asking them, Was that OK for you? Did they look after you well? Most expressed satisfaction as a summary of their feeling about the episode, but some expressed doubts about some aspects or stages of the incident. Overall, 24 per cent were clearly dissatisfied with care for an illness episode and 17 per cent in respect of an accident. This difference probably relates to distinctive adult interpretation and action in the two cases. Accidents tend to have visible effects, many can be dealt with easily and quickly, and treatment often immediately alleviates distress; so adults are likely to react fast and with comforting actions. Sickness bids are more problematic to school staff: illnesses are often invisible; staff may suspect faking or exaggeration or may evaluate minor illness and discomfort as less important than the child does. Methods of caring for illness satisfactorily are less obvious or certain, and since some feelings of illness are transient, staff may delay response. Teachers' weighing up of the relative urgency of the case versus the demands of school work are also a factor. As one teacher put it, 'Sometimes you have to put education before health.'

The principal reason children gave for dissatisfaction on accidents was that they did not receive the help they asked for (fifteen of twenty-six cases).

Dissatisfaction relating to children's claim to be ill was most commonly that an adult had not responded to their request for recognition of their ill status (twenty-three of forty-seven cases), and specifically in twelve cases the adults, mainly teachers, had delayed accepting the sickness bid — they had said, 'Wait and see how you go.' Others, when reflecting more generally on staff as caregivers — like the girl quoted above — expressed misgivings about staff responsiveness.

> Well, the dinner ladies don't listen to you most of the time and they just say 'Go away!' unless they see you're actually hurt. (Older girl, Town)

> Some [teachers] say, 'You're acting like a baby . . . Go away!' When it turns out to be serious, they say something different! (Older girl, City)

> [Teachers] can't be bothered. They hear too much of the same thing, and they're tired. (Older boy, Village)

> They never take you seriously — they just say, 'Go and sit in a corner!' and things like that; and if you've hurt yourself it's not very comforting. (Older girl, County)

Sometimes children thought the quality of the care given was poor:

> She just gave me a bucket and said to be sick in it. (Older boy, County)

> [For a cut knee] I got given a wet paper towel. That was it, really. (Older boy, North)

Our data show some differences from those collected by Alan Prout (1986) in the top class of a primary school. He found that 'most bids for the status sick are rebuffed' and children had to be determined and persistent to succeed; only dramatic, threatening and visible symptoms were successful. But his data are about one teacher and one top class where work had particularly high priority since selection for secondary school was in process. Our data across a wider range of situations and ages suggests a more varied response from teachers. Though some children's bids were refused, most received care and this ranged from the very good and highly appreciated to the poor, minimal, dismissive, or off-hand.

In many cases, children's satisfaction seemed to derive from quick and decisive action by an adult. But a major reason for satisfaction was that a parent (usually mother) came to take over the caring work. Children may have chosen to focus on episodes where parents did take over at school as episodes important enough to recount. And since most children thought parents and other family members were the main caregivers, they would regard parental care as the best option in case of both accident and illness. These children offer general reflections on the care system at school:

> When I have a sore tummy I tell the teacher to phone up my Mum and she says lie down and see if it gets better. And I lie down in the home corner where there's a few cushions. (Younger boy, City)

> *I*: Do they care for you at school?
> *Girl*: Yes, they do care, cos if you feel really ill, they ring your Mum and Dad and they come and pick you up . . . And there was an accident — and they fell off and hurt their back; and an ambulance came and took them to hospital. (Older girl, Town)

> *I*: Do you think it would be OK if you were ill or had an accident?
> *Boy*: Yes. Like somebody had asthma in our class and they called her Mum, and called people and stuff and looked after her. (Older boy, Village)

> I once did something to my leg — I couldn't move it. I twisted my ankle. They took very good care of me. They put me — they phoned home, and they carried me into the office . . . They were really helpful and caring. It's a very good school . . . If we're really ill, they're OK. (Older girl, City)

In all, children said parents were called for and came for seventy-five of the 192 illnesses (39 per cent), and for fewer of the accidents — twenty of 156 (13 per cent). In only seven illness cases and one accident case did the child or teacher try but fail to get a parent or other carer to come. It is understandable that parents should be summoned more for illness than for accident, since, as noted above, complaints of illness are difficult to assess and to deal with, and, as some staff explained, they thought it preferable to hand the child back to the responsible parent. Minor accidents can be treated and the child made to feel better at school.

A notable absence in children's accounts of the health-care system of the school is the school health service. Very few mentioned SHS staff as health promoters, as caregivers or as sources of information or advice. As the girls quoted here noted, children appreciate a kindly person, whether trained or not, who has the time to give for counsel.

> The teachers said, 'Sit in the office' and it [foot] was nearly broke [after a bench fell on his foot]. They can't do anything about it — I think they should have doctors here from when school starts till it finishes. That's what this room [SHS room] is for. (Older boy, City)

> *Girl 1*: [on the school nurse] She's OK, very good. She's not here very much. It would be nice if she was here all day for advice — she could use this room [SHS room].
> *Girl 2*: It doesn't need to be a nurse, just a nice person to sit here and be here if you're lonely.
> *Girl 1*: Just come in — talking to friends is no use. (Older girls, City)

Comments

We have explored here children's understanding of the school as a health-promoting institution. A central theme is children's own control over their own health care. Whilst children, like the teachers, have to work within the given physical environment, where and when they spend time is largely within teacher control not their own. Many children dislike the obligation to spend time each day in the playground. The social order is constructed by children within the framework of that obligation. Schools are beginning to recognize the right of children to participate in policy-making to modify the social order — through policies on bullying and on playground improvements.

As to health promotion through exercise and food, what is available to children is structured by large-scale policies on the National Curriculum — which affects the amount of time for exercise; and on catering — which has altered (for the worse) nutritional standards in schools. School staff operate in conditions not of their own making, and children's access to exercise and good food is within these local operations.

Finally, the health care provided in school for minor illness and accident was experienced by the children within the context of their understanding of the division of labour — where parents and they themselves are the principal people responsible, but where day-to-day responsibility rests with the school. From the children's point of view, there is sometimes a disjunction between the educational and health-care functions of the school, and their access to care depends on the individual initiative and willingness of a range of adults.

As we have noted earlier (p. 74), the SHS is not designed as a service for children but principally as an epidemiological and defect-spotting service. But as the last two quotations from City children indicate, they see a function for the school nurse for illness and accident and as a source of advice and comfort. The survey data on accidents, the children's accounts of accidents and illness, the numbers of children in mainstream schools with chronic conditions, and the current policy emphasis on health education and promotion at school, point to the importance in schools of health-related care and education. This raises the question whether professionally trained staff should be available to offer them services. In our schools, some staff had first-aid training, and a few had some medical training. We take up the discussion of the lay health-care system in the last part of the book.

PART IV

Discussion

Discussion

Introduction

This study has been carried out during a period of great change in primary schools, since the introduction of the National Curriculum, testing, devolvement of budgets to schools, and in the context of increasingly stringent limits on education expenditure. Judging by media reports, educational standards have been a focus for mounting concern. Governmental emphasis on test scores, the principle of parental choice, new responsibilities of governors, have all been cited as fuelling this concern. In the midst of this confusing and changing scene, our study has aimed to consider the status of children's health at school: the physical and social environment, intersections of education and health, the input of various agencies and staff; and children as social agents in the maintenance and restoration of their own health.

Teachers' resilience and inventiveness in the face of change has been striking. As one headteacher said, 'You have to keep moving on, to keep the school alive; schools do not and cannot stand still.' Thus, 48 per cent of survey schools listed planned improvements for the coming year, and a fifth had specific plans for the physical environment. All our six case-study schools planned to improve the environment, and five had earmarked or attracted the money to do it. North School had most difficulties finding money for improvements; it was in the worst position: falling rolls meant less money at a school urgently needing major refurbishment. The principle of *per capita* budgetary allocation punished the disadvantaged. The double disadvantage faced by children living in a socially deprived area, and spending their days in a dilapidated school building, points to themes that have run through our work concerning relationships between schools and the wider world. Schools' functioning as health-related environments for children relates to relationships with their local catchment population, to the quality of local services, and ultimately to the governmental policies that influence these.

In this last part of the book we draw together the points that have emerged through it; we trace the threads of the themes with which we started in order to consider the fabric they make up. Our main, central topic is:

- the status of children's health at school

and within that the issues to be considered are:

- interrelationships between agency and structure;
- the division of labour for the care of children;
- ideas about what children are and should be.

Agency and Structure

Policies and People

We have studied the physical environment within which children and adults spend their day, and what modifications to it people make. At a level slightly above this micro level, we have considered the impact of local services and systems on school life and how adults in school work with these. We have also pointed to the relevance of national educational policies in shaping children's lives at school, through the legacy of past policies (for instance on school building design) and through implementation of current policies — for instance on class sizes, and the National Curriculum.

A physical reminder of the legacy of policies is the buildings and playspace where today's children spend their time. As the survey showed, 30 per cent of primary schools were built before the twentieth century. These include school houses in villages, and three-storey brick buildings in cities. The age of a building was linked to satisfaction with it as a health-related environment, though not in a one-to-one relationship. Case-study respondents told us about the poor structural condition of 1960s buildings, and about the flexibility and solidity of Victorian buildings.

As well as the condition of the building, its suitability for today's education is in question. Only one of the case-study schools — Infant — was built to house its present occupants — an infant school. We thought, and the headteacher confirmed, that the building and playspace worked very well for staff and children alike. Of the other schools, Village operated in five buildings — four added piecemeal to supplement the original two-room eighteenth-century school house; it was unsatisfactory as a working environment for both staff and children. City was built for mass Victorian schooling, but offered plenty of inside space, though its cramped playground offered little respect for physical activity outside. North was originally a secondary school (1920s), with an asphalt playground, and children and staff regarded building and playspace as hostile. County was built in the 1960s as a primary, and was now a junior school, and had industrial classroom units added; it was structurally poor but spacious indoors and out. Town was built in the 1960s for smaller numbers and groups of children; it was now overcrowded, and some playspace had given way to extra classrooms.

A central issue in the above is the power of people in relation to the systems, material conditions and, more grandly, the structures within which they act. It has been argued (Shilling, 1992) that those theorists (in the 1970s) who conceptualized teachers as puppets of state policies disregarded their agency, their active work in context of, with and against current policies and practices. More appropriate, he argues, is Giddens' structuration theory (1979, especially Chapter 2), which proposes structure as both the medium and the outcome of interaction with agency. In describing and explaining the social world of school, the argument runs, we should examine the modifying interactive influences of teachers and social policies on each other.

We can consider this issue in more detail. Teachers clearly did regard their work and their interests as challenged by and in tension with the political, social and physical environment they were faced with. As the survey and case-studies show, many teachers viewed their task in part as one of fighting against odds; they won some limited battles but could not win the war. The number and scale of national policy initiatives leading to increased control over teachers justify this vision. Many teachers regarded themselves as attempting to hold the line for a humane, child-centred social world of school against an instrumental vision, harshly enforced. Their power to modify and improve things decreased along a continuum from school modifications through service input to central policies. Thus they could dig up the asphalt and make a garden (aided by LMS) and they could attempt better liaison with the health and catering services, but they had little power to stop assessment as prescribed, or to maintain certain staff–child ratios. The power and autonomy of the social policies within which teachers work was evident.

Children as Social Actors

Our attempt in this book is to put the children centre-stage as social actors. How then does their agency look in the face of structure? At one extreme, it can be argued that the issue is not worth considering: children have no agency within the structures controlled at micro-level by school staff, who themselves have severely limited power. As a minority group, children move to order, like puppets. Case closed. At another extreme it is possible to conceptualize children's agency as individuals and in groups in contention with the education system, at school level, or more radically against the system (Adams, 1991; Carlen, Gleeson and Wardaugh, 1992). A consensual model, between the two extremes, might argue that staff work with children for children's interests, in tension with social policies.

We interpose here the idea of children as a social group, an appropriate paradigm for understanding children's social positioning and agency at school. As a social group, children's interests and relationships to social systems are specific (cf. Prout and James, 1990; Mayall, 1996, especially Chapter 3). Thus children are not just members of families or of school classes. Their interests cross and transcend these settings. Social policies have different impacts on them, as a group, compared to the impacts on adult groups. Children here are regarded as social actors, who aim to order their own lives in interaction with adults. But they are a minority group who lack power to influence the quality of their lives. Specific to them as a minority group is that though they formally have rights (as set out in the United Nations Convention) these are not recognized in policy and practice; and in complement, most importantly, they have no political say, no vote. Others — adult groups and individuals — may work for what they perceive to be children's interests; but children themselves face frustration if they wish to work towards the definition and enacting of their own interests.

Here we can look at children's own understandings of their social position at school. Key to these is the character of relationships at school (as compared to home). Children leave at home each day the individual, affective, strong relationships developed with parents and find themselves in a social world where the teachers' remit emphasizes equitable relationships with the group of children. Whilst some children may work initially within expectations of individual relationships ('Some of them do tend to call me Mum,' said one teacher), they learn that more distant relationships with adults are the norm at school.

Children's Choice and Control at School

Undoubtedly, children have to learn the rules of the social order of school, but the learning also involves individual and group strategies to survive. Data collected with children, who are experiencing the first years of school, powerfully suggest that they regard themselves as making out, on their own at school. Children have to learn the rules of the school game quickly through what has been described as interpretive competence (Mackay, 1991), a task made more difficult by the fact that many of the rules are unspoken or assumed norms of considerable complexity (Waksler, 1991). An important first task for children on entering school is to survive as an individual, the second is to form a common front with one or more others — a necessary act as a form of solidarity and defence, though in time friendships and group alliances carry their own values (Mayall, 1994a). Thus school reinforces both children's sense that they are agents and their group solidarity.

Whilst children do not have choice in the curriculum, nevertheless learning within the curriculum is an important rewarding activity at school. Almost all the study children (85.5 per cent) singled out specific subjects or topics in the classroom curriculum as things they enjoyed. The central purpose of school provided children with an opportunity to act as individuals, to work on the project of their own lives through work. Activity of a more physical and social kind also attracted praise, with younger children enjoying playtime and older ones PE (see Table 3.1, p. 181). Notably, older children described PE in terms of individual and group achievement. So, in terms of what the formal and informal curriculum offered, virtually all the children identified some area where they felt a sense of acting within and towards something worthwhile.

Playtime — which may encompass one to two hours of a six-and-a-half-hour day — has often been regarded as a natural setting where children show themselves in their true colours, in games, songs and talk (e.g., Opie, 1993). Playtime has attracted attention as a critical setting for children's social learning (Sluckin, 1981), and as a setting for antisocial behaviour (Blatchford and Sharp, 1994). But school playtime, far from being a natural event, is better regarded as a highly structured time and space: generally it is compulsory to be out at certain times in the company of many children of varying ages and two genders in a space which may be more or less appropriate for safe and enjoyable experience. Children's comments on playtime in our study reflect these factors. Though children mentioned the disadvantages of playtime (compulsion, cold weather, dangerous places, overcrowding and aggression) playtime did offer limited opportunity for choice — what to play and with whom. Notably more of the younger children rated playtime as a 'best time' than of older ones. Some schools had provided protected areas for younger children, and the novelty of forming friendships and trying out games offered, it seemed, more pleasure to younger children; older children tended to prefer PE, which offered the chance of achievement — of new skills, of winning — and which provided activity within a clear social order of rules and conventions.

Achievement alongside delight in activity is an important theme in children's appreciation of aspects of school, as has been found in earlier work (Mayall, 1994a). But children dislike being constricted in time and space, as their adverse comments indicate on: keeping still, waiting for instructions, working long hours, working to order rather than by choice. Their sense of the pleasure of activity and achievement emerged in their talk about their favourite school subjects, as well as in talk about play and PE.

Children expressed their sense of being controlled through structures they had little power to alter. Children have less power than teachers. They are at the bottom of the pyramid of power. The view from the children strongly suggests that they recognized tensions between their view of themselves as actors and doers, limited staff recognition of this, and the constraints of the physical, social and academic environment. As the 'View from the Children' section showed, children working in adverse physical conditions — by adult standards — deplore these conditions: children spoke of getting lost in large buildings, of the noise, of the danger of crowded playgrounds. Children commented on dirty lavatories, and lack of privacy there. Notably, as regards the social order, the worst things about school were the behaviour of some staff and of some children: being told off and ordered about by staff, and facing aggression and bullying by some children. As to the academic structures, inevitably children found some topics less congenial than others — 48 per cent disliked some aspect of the curriculum. Among older children, the demands of the curriculum restricted activity; children noted that the balance between class work and physical activity was tilted too far in favour of the former.

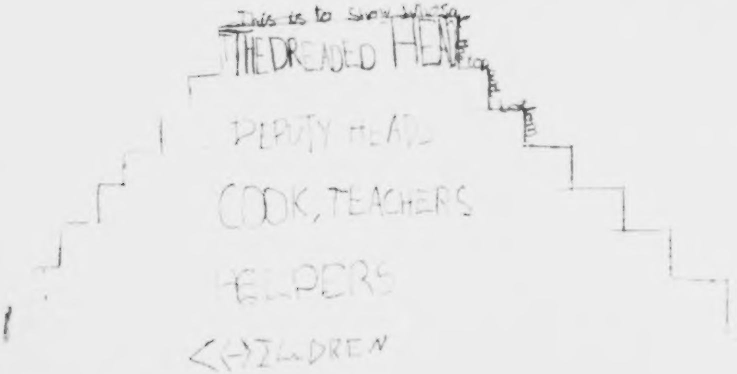

Figure 4.1 The school structure: 'This is to show who is at the top and bottom.'

Health Promotion and Children's Agency

Of particular interest in considering children's agency at school, in interplay with structural control, is the health-promotion agenda. We see here in policy and practice how schools work both to control children and to recognize their agency. Our survey presented outline data about schools' activity on promoting health at school, through specific teaching agendas (health education) and through more general attempts to promote healthy behaviour. We noted the wide range in activity, with 34 per cent of schools doing little and 20 per cent scoring highly on our index of health education. The case-studies reveal the individuality of each school: how each develops specific and locally appropriate programmes relating to health promotion.

Adults at school define and operationalize concepts of health promotion in a range of ways. At one extreme they emphasize children as social actors and their participation in modifying the social order of the school, and in working in the local community; and at the other extreme they understand children as objects of adult instruction, using an individualistic behaviour-change model. Health-promotion agendas in school are tied to national pre-occupations. *The Health of the Nation* (Department of Health, 1992) cites key areas for action, including accidents, sexual health, coronary heart disease and stroke, cancers, mental illness; the politics of health promotion currently favours individual behaviour change over structural change. In line with national pre-occupations and ideology, programmes and packages are developed by, for instance, the Health Education Authority, for use in schools (e.g., Williams, Wetton and Moon, 1989). However much these may stress children's active engagement with the topics, much of the agenda is already set. Morton and Lloyd's (1994) discussion of these issues reveals tensions between adult pre-occupation with teaching children what adults think they should know — and do; and incorporating children's views. More radically, the Child-to-Child Trust works with children to identify areas that concern them (Hawes and Scotchmer, 1993). For instance, a project in Knowsley was on dogs' mess — identified by the children as a major hazard in their daily life at school (Occleston and King, 1993).

The case-studies revealed that policies varied across the six schools; each had a different mix, and different strengths. North School had a whole school policy aimed at raising children's self-esteem through PSHE, and through a range of initiatives to engage children with participation in improving the social order of the school. City School, also serving a disadvantaged population of children, had similar aims and methods, but there was a particularly strong emphasis on direct action both to improve children's health through physical exercise and to teach children about linkages between the two. County School set health education within the framework of science teaching — here, it would seem, knowledge of how the body works, how health is gained and maintained formed the basis of formal learning. This school, like City and North, had established initiatives that enabled children to contribute to thinking about and working on the social well-being of the school and its children. Village School, the smallest school, with only five teachers, had designated one teacher as coordinator for health education, PSE, PE and science, and she regarded these as 'coming under one umbrella'; cross-curricular methods were used. In this school, the loading of all these topics onto one teacher encouraged coordinated thinking about the topics. Village was also strong on encouraging community-oriented activities — facilitated by close and complex networks between the school and local people and organizations. Infant School, a small school whose headteacher acted as coordinator of health education and was in an influential position to implement policies designed to make the school a harmonious and healthy environment, seemed to have a particularly highly organized health promotion remit, across both the formal and informal agendas. Finally, Town School had a worked out curriculum for health education and had also worked on whole school behaviour policy and practice; though staff thought health education was being pushed out by the demands of the National Curriculum, they were trying to link it in with science.

The picture is complex, and its character depends on policy, practice, individual initiative and focus, and on other pressures in the school. Emphasis on the formal and informal varied within schools, with teachers doing more specific subject work with older children and more cross-curricular and opportunistic formal work with the younger. In addition, teachers of younger children carried out social training on hygiene and diet, by monitoring and modifying children's behaviour. Here, teachers were continuing mothers' social functions — and indeed these were the two health promotion topics most frequently noted by mothers as important at school.

Children may experience themselves as both subject and object. In the same school, children may be taught how to behave on a group basis, have their behaviour as individuals monitored and modified, work actively on health-related projects, and take part in planning and implementing policies. In our six schools, children's active engagement was a notable feature. They variously: took part in putting up displays of their work; planned and wrote a booklet for newcomers to the school; wrote a charter of staff, parent and child responsibilities; served as members on a school council; did secretarial and administrative work; worked with nursery-age children on-site and with playgroup children and old people locally; painted walls in the playground; gardened; helped devise bullying policies and monitored their implementation.

Children faced certain contradictions within the formal and informal agendas and conditions of school. Health education messages might conflict with the physical and social conditions. Children who were overcrowded in class, and thought they needed more physical exercise, might be taught the merits of activity. Some children were faced with lavatories and wash-basins which failed to measure up to hygiene messages, and were almost certainly below the standards they lived with at home. And, notably, food provided at school was likely to include unhealthy components, judged by health education messages, and by family standards. The school as a health-promoting environment was faulty in important respects.

These contradictions are mirrors of conflicts within national policies. These emphasize individual over collective responsibility for health, yet regard children as the objects of adult input. Health education guidelines give little weight to children's responsibility for participation as individuals or as a social group in developing a healthy social order at school and locally (NCC, 1990b); yet under *Environmental Education* and *Education for Citizenship*, their participation is recommended (NCC, 1990c and 1990d). The physical condition of our primary schools is deteriorating and children and staff are finding it hard to maintain a healthy physical and social environment. These conflicts are evident in the distortion of the WHO (1993) European Network of Health Promoting Schools in the UK context. The WHO programme has three main aims: to provide a health-promoting physical environment; to promote individual, family and community responsibility for health; and to encourage healthy lifestyles. Yet, as implemented in the UK, it seems that most of the emphasis is on modifying lifestyle (NFER, 1994; HEA, 1995). The importance of decent physical conditions as a basis for health-related responsibility and behaviour is not a central issue.

However, judging by our case-studies, schools are developing policies and practices which seem to be raising the status of children as health-care actors at school. Schools are recognizing again what the kindergarten tradition established a hundred years ago: that children can take pride in participating in improving school grounds, for instance through planning layouts and through gardening (Titman, 1994). Teachers were consulting children about the issues to be addressed in contracts and charters both in school and across the home and the school. A particularly important trend is on bullying, where, probably partly because of the recommendations of the Elton Report, *Discipline in Schools* (DES, 1989), school teachers have consulted children on what the problems are and how to deal with them, and have incorporated children into

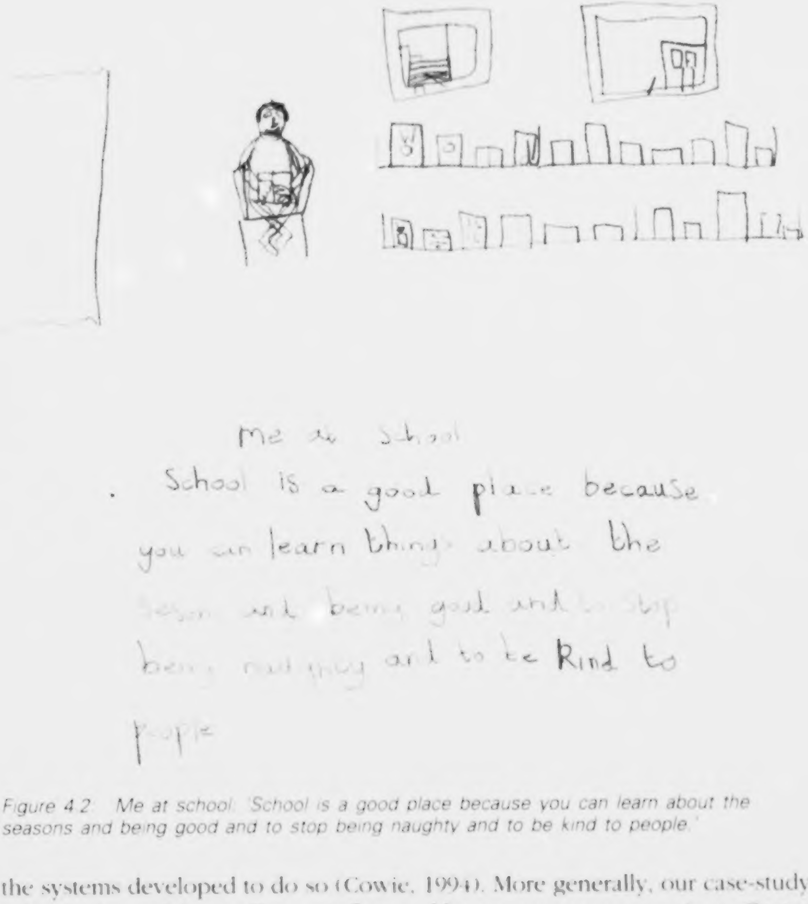
Me at school
School is a good place because
you can learn things about the
seson and being good and to stop
being naughty and to be Kind to
people

Figure 4.2 Me at school: 'School is a good place because you can learn about the seasons and being good and to stop being naughty and to be kind to people.'

the systems developed to do so (Cowie, 1994). More generally, our case-study schools showed that staff were influenced by recent programmes (e.g., Canter and Canter, 1993; Mosley, 1993) which stress conceptualizing children as active agents in improving school behaviour. All these trends, developing piecemeal and seemingly in conflict with wider educational policies, but possibly reflecting wider trends towards respecting children's rights, seem to be increasing children's participation in constructing the social order of the school.

Divisions of Labour

Divisions of Labour Between Staff

It has been one of the expectations and findings of this study that teachers are not the only important and influential adults in schools. Indeed, schools could

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not operate without the paid and unpaid work of those employed in secretarial, administrative, supervisory and caretaking positions. These people also carry out much of the caring work. Both LEAs and schools acknowledge this; it is non-teachers who most commonly attend first-aid training courses. Non-teachers' relationship to school, to teachers and to children is mediated through social background, training, job remit, and understanding of what school children are and should be. These factors position them in tension with teachers. Both interrelationships between these groups, and interrelationships with the social structures contextualizing their work, make for the complex social order of the school. For instance, some playground supervisors told us they did not attempt to sort out fights, beyond simple cases, but referred them 'upwards'; 'it goes higher than us' to the teachers. Others reported, and we observed, that some children behaved aggressively and dismissively towards supervisors, who in turn had little authority to deal with this behaviour.

If we are considering all the staff as agents who influence the character of the school as a social environment, then we have to take account of these staff relationships. This point has been largely neglected in the literature on education, presumably because it mostly starts from an adultist interest in teacher impact on children's academic achievement. If one starts from children's experiences at school, it becomes clear that a range of adults affect them. As discussed in 'The View from the Children', children seek and get help for illness and accident from a range of sources, including secretaries and supervisors, as well as other children and teachers. It seemed that the division of labour between staff varied broadly with the size of the school. In small schools, such as Village and Infant, all the staff lent a hand, depending on who was available; the system was ad hoc. In larger schools, clearer divisions of labour were established, for instance, teachers at Town did some first-line care, in case of illness, and then referred children on to the bursar (who had some training). At North, the secretaries' office, was the setting for most care — with other staff, including the headteacher, whose office was adjacent, lending a hand. The largest school, County, had appointed a welfare assistant to do hands-on care and treatment; by so doing the school had formally separated out teaching from caring functions.

However, the care system was also mediated through the physical arrangement of schools. At Village, where the two blocks of classrooms were in separate buildings and separate from the administrative block, each teacher had a telephone and first-aid kit in her classroom. And — a striking example — at City, the administrative office was large and had several staff; teachers came in and out, using the photocopier, liaising with the administrative staff. And since the headteacher's room was rather cut off physically from the main activities of the school, he spent much of his time in and around the office, which was strategically sited near the main thoroughfare of the school. Here, children would be cared for by whoever was available.

Whole school health-promotion initiatives are making overt what may once have been tacit and assumed. Policy discussions between staff — teaching and non-teaching — reveal an ill-defined situation, where the care of children is the formal or informal responsibility of many people. Professional interests, job remit and status are a further complicating factor, giving teachers, secretaries and supervisors distinctive 'takes' on children. Thus, within the school the social organization of staffing presents a forum for the agents to work out a division of labour. This may expose for review ideas about children's status at school and child–staff relationships, and may in turn modify the social organization of the school. For instance, if a school (as at County) sends supervisors on training courses about playground behaviour (cf. Sharp, 1994), and also integrates them into staff meetings, the social structure changes within the school with possible impact not only on adults' work and knowledge but on children's experience.

Schools and the Local Community

What schools expect of parents and other local people, and how they in turn understand their relationships with schools, emerges as a complex set of issues in our case-studies. In the first place, school staff tend to follow sociological tradition (e.g., Durkheim, 1961) in regarding the home as the first preparatory site of socialization and the school as the second, sequentially. The character of the home, and more specifically 'parents', is therefore regarded as crucial to the success of children in their early days at school. Thus Village School had compiled an information booklet for parents which described parents as the first teachers and went on: 'We will continue the education that you have so ably started to the best of our ability.' The booklet then described how parents should prepare a child for school, through encouraging physical, social and learning skills.

However, once a child is at school, two parallel, sometimes intertwined themes in school–home relationships operate: school as complement and school as compensation. The specific functions of the school in academic terms have been clarified and upgraded in response to the introduction of the National Curriculum. What schools do now looks more specific, as well as testable. Gone are the days when parents grappled with understanding just what their children were learning in the integrated day. Schools now have clear-cut, specific remits; in this sense they complement the more general educative remit of the home. However, teachers, especially of the younger children, maintain their self-image as people who also continue parental work, through providing care and individual attention, and social training.

The National Curriculum has also served not only to up-grade but also to redefine one of the traditional functions of school, preparing children for citizenship. Whilst preparation for, rather than enactment of, citizenship may form an important part of the discourse (NCC, 1990d), perhaps schools, as suggested above, are moving towards understanding children as citizens now — of both the school and the wider community — with certain rights as well as responsibilities. It is an interesting issue (one needing a research study) how far schools will work in complement to parental work here, and how far they will regard work with children increasingly as their province.

In tension with visions of the school as complement to the home, a second theme emerged from the survey and case-studies: that of the school as compensation. Whilst schools may describe, and even conceptualize, parents as able socializers of young children, tensions and rivalries between staff and parents emerge in teacher comments on undesirable characteristics and behaviours of parents. When survey respondents were asked to note down problems their school faced, parents came top of the list, in two groups, as disadvantaged and as inadequate parents. Compensation becomes a function of the school in response to homes defined as poor. However, that function is defined and operationalized in specific ways according to staff understanding of the problems. For instance, both City and North Schools catered for disadvantaged populations, with unemployment, poverty and poor housing affecting many families. Staff in neither school blamed parents, but aimed to help the children. City had implemented a vigorous policy of physical and social education to build the children's strength; various democratic initiatives aimed at increasing children's participation in the social order. North had put in place a whole school programme specifically aimed at improving children's self-esteem. The schools had distinctive approaches to work with parents. At City, parent groups — including minority cultural and linguistic groups — aimed to make parents feel more 'at home' in school. At North, where staff identified social disintegration as an acute problem, staff tried to encourage the idea of the school as a central focus for social life locally, and also asked for parental input to the school (which as a poorly resourced school it desperately needed) by issuing a booklet explaining the many ways in which parents could help.

The division of labour can be viewed from mothers' perspectives too. The first theme here concerns one of mothers' basic concerns: hygiene. In response to the questionnaire, more of them commented adversely on standards of hygiene (28 per cent of the eighty-nine parents) at their child's school than on any other topic, though school buildings (27 per cent), dinners (26 per cent) and space (24 per cent) followed close behind; more of them (41 per cent) than for any other topic wanted hygiene taught at school. One mother told us she inspected the toilets to see if they were fit for her child to use. Related concerns were with infection, and contagion. The physical as well as social environment of school aroused concern in a large minority of cases.

A critical issue for children, mothers and staff is the incidence of nit infestation. It provides a classic example of how the division of labour rests on varying service remits and priorities, and on ill-thought-out policies, including unrealistic expectations of the lay health-care system across the school–home boundary. School nurses no longer have head inspections in their remit — their priorities lie in screening. School staff are also barred from inspecting children's heads and, in any case, screening for health conditions is not in their remit. Both sets of people throw responsibility onto mothers. Where one child has nits, the only hope of eradicating the infestation in the class is for all mothers to treat their children and all other household members. For this to happen a number of conditions must be met on the same day: all mothers must receive notification; if mothers cannot or will not pay for the lotion then a GP must issue a prescription; all treatments must take place. Clearly the chances of eradication are slight and consequently nit infestation is a source of fury, shame and irritation to mothers and children. It seems that the health and education services, having designated this as a mothers' responsibility, rate this health problem as minor. If it were taken seriously, a combination of some of these measures could be taken: school screening of all children on demand; treatment at school; issuing of lotions to mothers; smaller classes or larger classrooms; insistence that hair be tied back or kept short.

All the evidence suggests, not surprisingly, that the health of their children at school was an important consideration for mothers. Parent interviews (almost all with mothers) indicate, as in an earlier study (Mayall, 1994a) that mothers regard children's physical health at school as critical for their daily experience, and comment abrasively on hygiene inadequacies in schools' physical and social environment. Examples are: 'dirty toilets'; 'dust and grime in the classrooms'; 'hygienic water fountain needed, so children's mouths don't touch it'; 'packed lunches should not be kept in the toilets'; 'cold storage needed for packed lunches'. The quality of meals provided is problematic for mothers. Children 'don't remember'; teachers do not know; schools do not all display menus. The evidence suggests mothers cannot rely on school to provide enough good food (cf. Mayall, 1994a, pp. 63–5). Safety is a major issue; dangerous steps and corners, unlocked school gates, unsafe playgrounds, and absence of seatbelts on the coach to swimming, figure in the comments. Mothers also regard themselves as responsible for their child's health at school, and wish to be called. For only 2 per cent of accident cases in the survey did parents not come if needed, and in the case-studies, findings were similar. Some school staff endorsed the view that children should be returned to their parents in case of illness and accident. However, the precise division of responsibility can be problematic. One mother was called to school to take her son home because the teacher thought he was ill; the mother talked with him and established he was crying not because he was physically ill, but because the teacher had separated him from his best friend.

No doubt mothers' feelings of responsibility are reinforced by the lay health-care system of the school, whose workings are obscure to outsiders and thus leave open the question whether they work well. It was notable that mothers in a group interview at County started the discussion by praising the new system — that there was a 'nurse on duty at the school full-time'; they thought this provided them with reassurance of quality cover, not offered at most schools. The new system at County had been possible partly because the budget for this large school offered more flexibility than that for a smaller one. Presumably few schools can afford to employ someone just as a health carer;

this was a rare example of a sharp division between health care and teaching. As we have noted, children experienced the new system variously: some deplored the division of labour — teachers should act as caring people; others found it had clarified remits and sources of help.

Teachers and the secretary at County indicated their satisfaction with the new arrangements too. Health care was one less issue for them to deal with. However, the increasing pressure on teachers consequent on rising numbers and requirements to teach specific sets of knowledge to a mixed ability group, may mean that children are increasingly likely to be referred home in case of illness and accident. If so, then the expectation that mothers both can and will combine paid work with child care will come under increasing strain. The time is long overdue, in that respect, that mothers' and fathers' child-care responsibilities be recognized as justification for taking paid time off during working hours. Currently, UK mothers, during their hours of paid work, do their child-care work clandestinely.

More generally, our study has been concerned with how schools relate to the local community. Schools have firm physical boundaries round them (required in safety interests), and vary in the metaphorical and social permeability of those boundaries. Apart from getting parents and others in to help with school work and raise funds, we have noted how schools moved out, interacted with local events and people, and directed attention towards local social and physical issues as part of environmental education projects and activities.

Here, again, we are faced with issues of definition. Some teachers lamented the breakdown of 'community' as evidenced by local and national reduction in proportions of stable two-parent households. Staff thought community spirit was declining in North's area of high unemployment, because it had destroyed a central focus of local understanding and commitment — generations of people working at the main industry. Community spirit was defined within traditional parameters at Village, where both individual relationships, cemented through kinship and neighbourhood links, and social relationships, expressed in attendance at social and religious functions, were regarded as relevant. Community spirit was given new definition and impetus in County's catchment area by the input of business sponsorship into the school, as well as parental financial contributions. Local people also took part in running out-of-school sports and social functions; thus local people expressed their sense of the importance of the school's success financially as well as socially.

It would seem that here, as in other areas of school life, changes in the education system in the 1980s have had positive effects as well as negative ones. The notorious traditional neglect by schools of children's out-of-school knowledge and experience (Barnes, 1976, pp. 84–5) may give way somewhat in the face of encouragement to study local social and physical life in science and environmental studies. Local management of schools and governor power in the face of stringent budgets forces the condition of schools onto local agendas, and may encourage financial and social input, as noted above. Schools, faced with pressure on staff numbers, may go out more consistently and more forcefully to recruit unpaid help. However, such interactions will also serve to increase inequalities in children's school experience; poor areas, including those with falling populations, can offer less to the physical and social health of schools.

Contributions of Other Services to Schools

The quality of children's experience at school will be influenced by a range of services, other than the education service. The headteacher at Infant School had devised a chart showing those people involved in providing for special needs children, but it has general applicability too. (See Figure 4.3, p. 220.)

In every case except one, she noted, staff provided a poorer service 'now' to the school in quality and/or quantity because of redundancies, unfilled vacancies, sick leave, or increased workloads over the last year or so. The exception was the school nurse who continued to offer a supportive service in general and for special needs children.

The division of labour between services, as we pointed out in Part One: 8 (pp. 72–7), rests on a set of negatives. There is no overall planning national agency for the education, health and welfare of school children, and no structures of coordination or collaboration locally between the many relevant health and social services and the education service. Guidelines will be issued by the Department of Health in 1996, making joint planning of services by health, education and social services compulsory, but we understand the emphasis is on targetting children 'in need' (Sutton 1995, Chapter 2). Joint planning for all children remains to be tackled as a national policy, though local authorities may opt for it.

A recent exemplar of the traditional separation of education from health is provided by the membership of the British Paediatric Association (1995) working party on *Health Needs of School Age Children*, which had no representative of the education professions. And the report follows in a long tradition: it recommends collaboration (p. 25) but lacks clear proposals for structures to enable and support it. The report observes that professions put boundaries around their work, for instance that the NUT has advised teachers not to administer medical treatments, and notes the 'difficulties' caused by teachers' refusal to administer drugs, for instance rectal diazepam for children with epilepsy. This topic, by chance, had been the subject of a staff meeting at Town School, where school-based care of a child with epilepsy was discussed. The ethics and practicalities of teachers giving medical treatment was debated, and the absence of advice and information about epilepsy from the medical service was deplored.

Undoubtedly, collaboration between agencies is difficult (cf. Sutton, 1995, especially Chapter 8). They are each likely to have distinctive agendas, will be subject to specific constraints and pressures, and will set priorities in the light

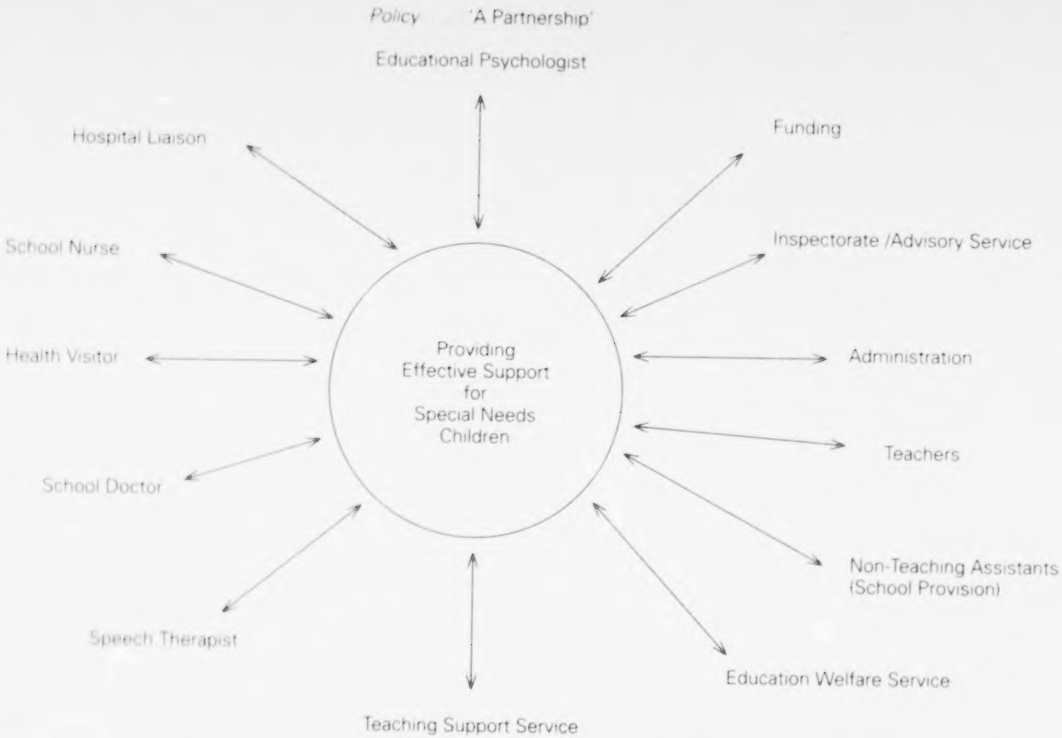
Policy — 'A Partnership'
Educational Psychologist
Hospital Liaison
Funding
School Nurse
Inspectorate /Advisory Service
Health Visitor
Providing Effective Support for Special Needs Children
Administration
Teachers
School Doctor
Non-Teaching Assistants (School Provision)
Speech Therapist
Education Welfare Service
Teaching Support Service

Figure 4.3 Policy — 'A Partnership' Chart showing people involved in providing for special needs children

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of these factors (cf. Fieldgrass, 1992, pp. 55–9). The time-frame for the planning and implementation of services may vary between agencies. Adequate collaboration also requires good personal contacts, and where staff are transient — on short contracts, or made redundant — this may be difficult. The quality of staff at both school level and at local authority education, health and other services level is key to success. Conditions of financial stringency make all these issues more difficult to deal with, and also raise other issues. For instance, it is tempting for one agency to blame another — as in the epilepsy case cited above — and staff pressed for time will devote less of it to liaison and collaboration.

The fragmentation of the many services is one problem affecting children's experience and well-being. Another is the inequalities in service provision. Our survey has shown how health service provision varies in quantity, and, according to respondents, in quality. Case-study information about frequency of nurse and doctor visits per year, set against the number of children in the school, shows wide inequalities of access (see Table A2.4, p. 243). At Infant School — the most satisfied with the service — the nurse (the doctor had left and not been replaced) would have to see only 4.5 children on each visit in order to see all children each year. At Town — one of the most dissatisfied — SHS staff would have to see 23.3 on each visit. At County, SHS staff would have to see 30.5 children each time; the nurse here thought that a school with 550 children should have a nurse on site, however the welfare assistant did carry some of the load.

As we noted in respect of survey findings, there were no relationships between school factors and the SHS service provided. In other words, the service operated to satisfy other goals than responsiveness to numbers and needs in school. As one teacher tartly noted:

> No school in the borough has the health back-up to support children through problems or illnesses, or complaints about mistreatment. You hand your child over to a welfare lady who may have been on a first-aid course twenty-five years ago.

Furthermore, in line with the absence of coordination higher up the line, schools are poorly placed to influence the goals and character of local services. This may explain why liaison systems at school level were poor — teachers had no established part, generally, in policy and planning for these services. The survey indicated that only half the schools (53 per cent) had formal liaison between the headteacher and the SHS; and whilst similar proportions (51 per cent) reported some kind of liaison with the catering service, only 19 per cent cited policy discussions.

Finally on this, we note that the existing and traditional division of labour between agencies for the care of children at school, with its separate services and absence of coordination, may work adequately where schools have generous staffing. That is, the traditional add-on character of women's work —

with child care added to the formal job remit — may provide good care where teaching and non-teaching staff can comfortably carry out their formal job. Under current conditions of service, however, caring may become a problematic extra, rather than an integral feature of women's work. Two outstanding issues here are staff–child ratios, and the incidence of children with chronic and special needs in school.

On staffing, again, we have to note the inequalities suffered by children across the survey schools. Smaller schools offered children more chance of attention from staff (i.e., all types of staff); and so did rural schools, which tend to be smaller.

We asked the case-study schools whether they had lost or gained in terms of numbers of children and staff for the academic year 1995–96 (see Table A2.5, p. 243). Three of the schools were gaining in numbers of children, and two of these had gained in staff: a classroom assistant (County), a teacher and two special needs assistants (City), but Town had no staff increase, and so faced especially large class sizes. North slightly reduced its numbers of children, but lost one teacher — which left it with larger class sizes. Both Infant and Village had stable numbers of children and had gained some non-teacher assistance, earmarked for a special needs child at Infant. Thus, this small sample provides a picture of stable or worse teacher–child ratios, but with some non-teaching help improving staff–child ratios in two schools. Nationally, we understand teacher–child ratios are worsening (*Guardian*, 3 October 1995), although official figures lag behind the increases (*Guardian*, 26 September 1995).

Alongside teacher–child ratios, we need to consider an additional feature of teacher work. This is the extra demands resulting from the integration of children with special needs into mainstream primary education, along with the continuing and possibly rising proportions with chronic conditions (as suggested by the BPA, 1995, p. 2). In our six schools, we asked class teachers how many of their children needed extra care. Among our 264 children (in ten classes), teachers mentioned twenty-six children with chronic conditions: of these eighteen had asthma, one diabetes, three epilepsy, one cerebral palsy, one a heart condition, one a hearing problem, one a sight problem. They also mentioned many dubious cases, especially of hearing and sight problems; and some mentioned, but were sceptical of, further children's claims to have asthma. In addition, they specified eight children with special needs, including both physical and behavioural problems. In all, therefore, at a minimum estimate, teachers in our ten classes had thirty-four children needing extra care, that is 13 per cent of 264, or, on average, 3.4 per class.

Coupled with large classes, where more children will report minor illness, these figures suggest children must increasingly compete for teacher attention in class, even if other adults help in the office or playground. If the picture of increasing proportions of non-teaching staff reflects a national trend, there are implications for the organization of the health-care system in schools, with possible further divisions between teaching and care as adult functions.

Unfortunately, as far as we know, there is no other data on this topic with which to compare our findings. Large classes and integration policies, in the context of divided services, raise important but largely neglected questions about children's health status and health care at school.

Children and Childhood in the Division of Labour

Thus far we have considered impacts of the adult division of labour on children. Here we take account of children's participation. As discussed in 'The View from the Children', children indicated their understanding that the home was the site of health care, with parents (mainly mothers) as the principal people whose job it was to keep children healthy and themselves as taking more responsibility with increasing age; 44 per cent of older children identified only themselves as responsible for self health care (see Table 3.2, p. 188). It was noticeable that many of the illness episodes that children chose to relate ended with the mother taking over the care (41 per cent). It may be that they chose to describe serious or dramatic episodes, involving several stages of care, and phone calls home. But the fact that children's satisfaction overall with the care they received is related to their mother coming to pick them up, suggests that it was her care that (at least in part) determined their satisfaction: mothers are the right people to care for you when you are ill.

Children's identification of the home, parents and self as health carers is in stark contrast to their view that the job of health care and health promotion is not that of school staff; only 15 per cent of older and no younger children cited school, teachers or other staff. Yet it is teachers and other staff who determine and maintain the social order of the school; health education is now formally part of the curriculum, and staff are urged to promote health more generally.

We can say, then, that at school children experience a social order where adults whom they do not regard as health-carers hold the reins: they are in charge during the school day as health educators, and they control both children's health maintenance, and deal with illness and accident. Our data indicate that children are fully aware of how the adult-ordered regime of the school structures health maintenance. Eating, drinking, excretion, play and physical activity, including PE, take place when the adults say it may and will; the standards of the physical environment, including buildings, playspace and toilets, are 'given' as symbolic markers of the environment adults think appropriate for children (cf. Titman, 1993, pp. 79–98). As regards accidents and illness, adults act as legitimators, offering recognition and care according to their judgment.

The children told us they adopted a variety of strategies in face of this control. Some save up their hurts till they get home — mothers commonly find themselves subjected to demands to recognize and deal with health problems the minute children come home (cf. Mayall, 1994a, Chapter 5). Some children

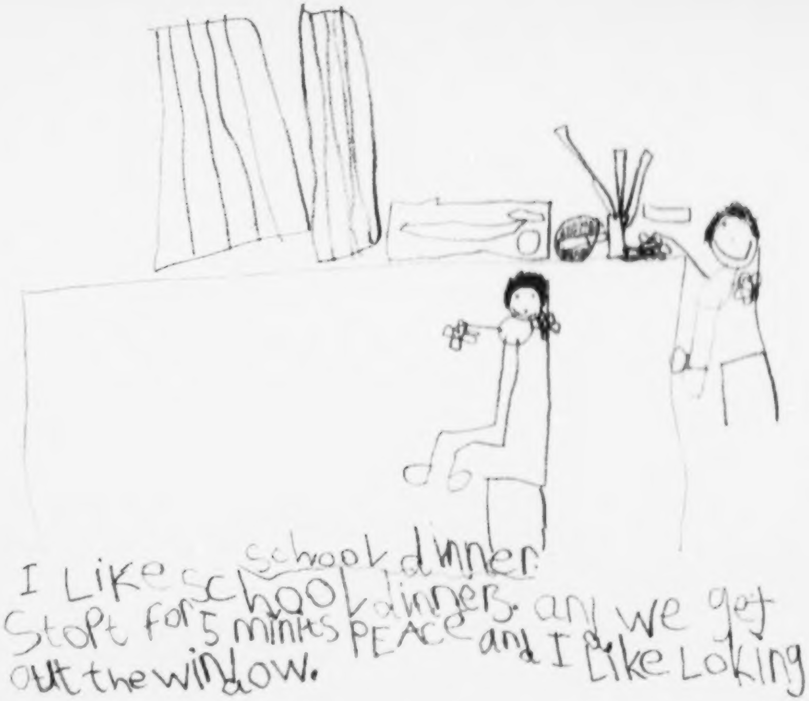
school dinner
I Like school dinner. and we get
Stopt for 5 minits PEACE and I Like Loking
out the window.

Figure 4.4 School dinner: 'I like school dinners and we get stopped for 5 minutes peace and I like looking out of the window.'

derive strength to ask for adult help for illness by organizing a joint approach with another child (cf. Christensen, 1993). It seems likely that some of the tactics children adopt to avoid work are attempts, among other things, to regulate their own well-being. One boy said the advantage of the outdoor lavatories was that you could take your time getting there and back, thus getting a bit of fresh air and a change from the classroom. In some cases, children dealt with illness and accident, if it happened at playtime, by themselves. Stoicism featured in some boys' accounts.

Schools confront, and deal with, a conflict between the idea of children as social actors, held by the children, and the idea of school as a socializing and formal teaching and learning institution, where adults are required to regard children as objects of their work. As has been noted earlier (p. 210), it is notable that schools seem to be moving somewhat towards the children's own position, in health promotion activities, including those relating to the improvement of the physical and social order of the school. Children may thus find themselves occupying more than one set of social positions, vis-à-vis school and its adults.

It has been suggested that children in the UK are commonly regarded through welfarist spectacles, as either victims of adults or as threats to the adult social order (e.g., Hendrick, 1994). Children are regarded as needing protection, a 'need' based essentially on their position as persons proceeding through developmental stages towards adulthood, and on the dangers posed by the adult social world. Children, traditionally, are the object of the caring work of school staff; for instance, the phrase 'caring staff' or 'a caring school' ran through survey comments on the strengths of school. Children as vulnerable people to be protected and helped through difficulties is part of the discourse both of mothers and of those who take their place during young children's school days. Probably one of the main underlying causes of teacher discontent with government policies in the 1980s is that these seem to reject children's need for care and to re-define children as fodder — numbers in an attainment race, to be used to attract more children, and so more funds, into school. One kind of opposition to this view of children is the long established and still widely held Plowdenesque understanding that children should be enabled to learn through experience (cf. Pollard, 1996, p. 312). Yet this view rests, in the case of what teachers are taught, on Piagetian principles (Gipps, 1992), which in turn suggest children as incompetents as compared to adults. Finally on this, we may note that health and social services are increasingly operationalizing the idea of children as victims; traditional universalist services are giving way to services targetted at those children deemed to be at risk — physically, socially and emotionally.

In complement to the child as victim, there is a common vision of the child as threat; they may pose threats to other children and/or to adults, to individuals and to the social order. In the case of children at school, the policies which ensure the construction of large groups also ensure that children have to be controlled. Large numbers of children in small spaces produce adult efforts at control, whatever the educational ideology. Even the Plowden classroom needs some order, quiet and routine if it is to work well; so, too, does the class of children learning Key Stage material, through whole-class teaching. Some teachers, themselves, deplore the need to control children. Children rated being told off or shouted at by adults as one of the worst things about school (along with other children's aggression). Staff often cited conflicts between their control and care functions — you want to be a mum to them, but you have to keep order.

An important issue here is children's social positioning as products of maternal care and as recipients of ideal care at school. It is commonplace for mothers to be ascribed responsibility for their children's character and behaviour, and school staff, like many people, offered adverse comments on some mothers' child care behaviour. By contrast, by tradition, teachers regard primary school as a model environment, developmentally appropriate, providing care and stimulation. It seems likely, judging by our data, that school staff increasingly think that school as a model environment for children is under threat. The data indicate that physical conditions, overcrowding and the formality of curriculum demands are making serious inroads into teachers' understanding that they provide a model service. They cannot see it as the best possible environment for children or as a model for parents. In this connection, the growing perceived need to attract mothers into school as helpers is interesting: Will their contribution be more highly valued by teachers as their own job becomes more difficult? For children, it may be that more distant relationships with hard-pressed teachers, struggling to deliver the National Curriculum are complemented by increasingly important relationships with the non-teachers and unpaid helpers, including mothers, brought in to help.

The Status of Children's Health in Schools

Finally, we return directly to the central issue addressed in our study: the status of children's health in schools. There are no easy answers. Some points are discussed here, concerning: the impact of policies on children's health status; varying perspectives at school level; children as individuals and as a group in the social order; and prospects for the health-promoting school.

Adult Input — Policies in Action

Our exploration suggests strongly that children's health status is low on the priority list of most of the policy-makers and agencies that provide input to schools. The absence of coordination and consultation between education and health services is a basic problem that impacts down through the system to school and individual level. That disregard for the whole child is shown in the physical character of buildings and playspace, the variations in these, and the low priority given to improvements. It is also shown by the commercialization of the catering service, which again has no formal links with education. We heard from case-study schools that reductions in social work and psychological services are also taking place without consultation with the education service.

The withdrawal of power from local education authorities (LEAs) consequent on the allocation of funds directly to schools (LMS) has signalled changes in the health status of children. Staff in schools, to the extent that they do take account of the whole child — and our evidence suggests they try to — can now make improvements without reference to the LEA. Our respondents indicate that this allows for speed, flexibility and individual initiative. But tight budgets mean that action is limited in scope and impact. And, in complement to devolvement of budgets, the way is opened for inequalities in provision, as we have documented. *Per capita* funding and variations in local wealth as a resource for schools are both factors here.

Implicit in the poorly coordinated, poorly funded and uncaring policies, is the assumption that the lay health-care system of primary schools, organized and delivered by women employed to do other jobs, will cope. And that where they cannot or will not, mothers will take over, sliding clandestinely out of their workplace to do so. We do not know (except as mothers ourselves) how well this system worked in the past, although there is plenty of evidence of the strains imposed on mothers of pre-school children, when they juggle paid work with child care (e.g., Scarr and Dunn, 1987; Moss, 1990). The lay health-care system in primary schools is cracking under the impact of government policies. Large classes, overcrowding, the National Curriculum and testing are likely to increase the amount of stress-related 'minor' illnesses children suffer at school. Simultaneously, under the impact of the same factors, teachers' work is becoming more time consuming and stressful. The secretary — traditionally a key mother figure — has increasing quantities of paperwork, including budget work, and less time for children. And the presence of children requiring extra care and, in some cases, specialist knowledge, coupled with decreases in support services, increases teacher difficulties in responding to children's expressed and latent needs. The complementary child-care work of mothers is also increasingly difficult, now that even more of them go out to work; the child-care responsibilities of fathers are not recognized in UK policy and practice (Cohen, 1988).

Perspectives on the Status of Children's Health at School

The above presents our views of the general picture. At school level, mothers and staff have their own distinctive perspectives on the status of children's health. Mothers indicate that they regard themselves as having continuing responsibility for their children's care during the school day, and their comments reflect this position. Thus they deplore poor physical conditions, praise the caring work of staff, negotiate care of their children with teachers, and regard the school health service as only marginally useful (Mayall, 1994a, Chapter 7; cf. Ribbens, 1993).

To some extent, staff views on the division of labour mirror mothers' perspectives. Staff do what they can to improve physical conditions; give high status, in policy terms, to child-care practices; and respect mothers' requests and accounts about their children's health care. They regard the SHS as potentially a source of information and advice, but in practice find it severely limited. But as indicated above, their ability to care for the children in practice is jeopardized by prevailing conditions of work.

Further, the issue of child-care knowledge is important in structuring mother–teacher negotiations. Whereas teachers regard themselves as experts in the psychological development and care of children, mothers' experiential knowledge links the bodies, minds and emotions of their children (Mayall, 1996, Chapter 4). The idea — promoted in policy as well as through simplifications of developmental theory — that the best mothers are those at home full-time with, and for, their children provides teachers with an understanding of how mothers should behave (cf. David, 1993a). For their part, mothers struggle with the same idea in the context of the material and social interests that structure their decisions about balances between paid work and child care. These differences in perspective lie at the heart of the relationships of mothers with teachers. Traditional boundaries between home and school, and traditional mutual suspicion make such goals as partnership problematic both in theory and practice.

Children in the Social Order

Our evidence suggests that children themselves regard the home and its members as the site of health care, rather than the school. From their point of view, essentially, their health status is on hold during the school day. Children comment on physical conditions, food, exercise and care in the context of the formal agenda, and recognize clashes between health-related messages and experienced realities. Where their agency is recognized by staff, children are highly appreciative.

More generally, we should contextualize these findings in understandings of children as social actors, as members of a minority group, and as people whose rights at school are in question. The basic position adopted in this book is that children regard themselves, and are most appropriately regarded, as social actors. Their activity at school, as workers and as people pacing their day, as bodies and minds, is in tension with the formal functions of school as currently understood and operationalized. For an important strand in policy proposes children as units to be processed in order to gain the maximum output in terms of achievement at minimum cost. Children, it has been argued, are the objects of adult work (Oldman, 1994); schools are for schooling rather than for education. The question explored here is how far teachers and other staff do in fact operationalize these policies, given their perceived status as a caring profession, their grounding in more liberal educational traditions, and social trends encouraging engagement with children as agents. We have suggested a complex of tensions between the control and caring functions of school. And the complementary question is how children manage their bodies and minds in tension with policy and with staff behaviour. We have documented children's delight in activity and achievement both in class-based work and in physical and social activity at playtime and in PE sessions. They are also keenly aware of the controls operated by staff — expressed through the regime and through commands and reproof — and of the stresses under which staff operate.

Children must also be understood as a minority group, socially, economically and politically. This is reflected in the physical conditions of schools and the health and safety regulations, which (see pp. 72–3) give inadequate and poorly regulated recognition to children's health, safety and well-being, as compared to adults. More generally, the minority status of children is evidenced in the political construction of their social position in school as preparatory;

they are there to learn the skills and knowledge required for their future status as adults. Their present is less important than their future.

Children's rights within this scenario look fragile. Their rights under the UN Convention on Children's Rights are at issue: the right to participate in decisions and procedures that affect their lives (Article 12); and the right for actions concerning children to take full account of their best interests (Article 3). There have been no moves at ministerial education levels to implement the Convention, signed by the UK in 1991, and, reportedly, the Department of Education and Science claimed that no action was needed since it already complied with the Convention — presumably, by providing free compulsory education (Article 28) (Lansdown, 1994). Indeed, the DES Parent's Charter (1991) emphasizes parental rather than children's rights. Interestingly, the prose was slightly altered in the 1994 update to include a few references to children's rights: thus the up-date suggests that children themselves be offered advice on subject options at age 14, and on educational choices at 16 and thereafter (DFE, 1994, p. 17); 16-year-olds are referred to as 'young people', but people below this age are generally conceptualized in the Charter as 'children' — meaning dependents of parents.

However, it was one of the most encouraging findings of this study that, at school level, children's rights were increasingly recognized. As suggested earlier (pp. 210–13), a range of issues may explain why teachers are turning to children and asking for their views, and for their participation in planning. They perhaps arise from staff concerns with how to improve behaviour in schools, how to operationalize health education/promotion, and how to counter the harshness of national policies as experienced by staff and children. However, it remains the case that children have no participation in determining the most critical features of their school lives: the formal agenda — what their education should consist of; and the informal agenda — how their days should be spent.

The Health-promoting School?

Children's powerlessness brings us back, finally and briefly, to the idea of the health-promoting school. Our position essentially is that empowerment is both the key and the least likely component of health promotion as it concerns or involves children at school. Empowerment comprises: firstly, a physical and social context which facilitates and encourages health-related decisions; secondly, addressing the agendas of the people concerned; and thirdly, working with them to develop relevant knowledge for implementation (cf. Kalnins, McQueen, Backett, Curtice and Currie, 1992; WHO, 1993). A further issue, as Keith Tones notes, is how generally the social values that underlie the aims of health promotion are accepted (Gibson, Leavey, Sands and de Viggiani, 1995).

Given that the physical and social environment of schools is in some, if not all, cases unhealthy, the first block in the empowerment pyramid is

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removed. Given the National Curriculum, the second block is at risk: it is very hard for teachers to address children's own agendas. Thirdly, within the context of limited time, it is hard for them to work with children to develop knowledge (far quicker to give information and precept). All three components of empowerment look distinctly shaky. And finally, as research studies show, people do not necessarily accept the ethical assumptions and social values underpinning health education and health promotion agendas (e.g., Freund and McGuire, 1995). Indeed, their concepts of health itself may vary (e.g., Herzlich, 1973; Russell, 1995). In the case of children, it is hard for adults, socially positioned in authority and with their own as well as national agendas, to respect children's views. The up-side is, as we have noted, that within these limits teachers do seem to be working with, as well as on, children. And children themselves, as individuals and as a social group with unique knowledge and experience of school, understand the limitations within which they and their teachers spend their days. Knowledge constitutes one essential but not sufficient factor towards empowerment.

Children emerge from consideration of the health-promoting school as very poorly placed to construct their own lives on a satisfactory basis. The absence of coordinated policies committed to child health at school makes the idea of health promotion there a mockery. We should like to see, as a matter of national priority the upgrading of education and health as linked concepts. We leave the final word to one of the survey respondents, working in a large school in a deprived area of north-west England.

> Children's education, health and well-being has to be a national priority set by government legislation. Until this is greatly improved we are all fighting a losing battle. Too many policies to deprive our already underprivileged children — I could write a book on this.

Appendices

Appendix 1 Health in Primary Schools

The Survey: Method and Questionnaire

The Sample

An important consideration in planning the questionnaire was how to collect sufficient data without overloading school staff. We needed to cover a wide range of topics, but did not wish to ask staff to spend long on answering questions. We also wanted as many as possible to reply, in order to have good numbers and reasonable representation. We decided on a four-page, eight-sided questionnaire. Inevitably we had to limit the questions to mainly factual points and to ratings that could be quickly completed. We also left space in each section and at the end for comments.

In a letter to each of the 120 LEAs throughout England and Wales, we outlined the aims of the research and sought permission to approach schools within the authority. All the LEAs gave us permission, although Gwynedd agreed on condition that the questionnaire would be available in Welsh. Twelve authorities requested to see a copy of the questionnaire. LEAs noted that participation in the project would ultimately be the decision of the headteacher.

In September 1993, a pre-pilot of the questionnaire was sent to three headteachers known to the researchers. After refinements using comments from these, pilot questionnaires were sent to nineteen schools in inner-city, rural and small town areas. The questionnaire was further amended in the light of this experience. Using a 1 in 20 sampling system we selected 1031 schools from approximately 20,000 schools throughout England and Wales listed in the Primary Education Directory, 1993 representing each LEA. The questionnaires were sent out at the beginning of November 1993; they were addressed to the headteacher and requested a reply by the end of the month, or as soon as possible afterwards. As well as the questionnaire, each school was sent a covering letter explaining the aims of the research, giving numbers to contact for more information, and a reply-paid envelope. Schools in Gwynedd were sent both Welsh and English versions of the covering letter and questionnaire. A postscript was added in the covering letter to the remaining Welsh schools, offering a translation if required (in the event, only one school asked for this).

Response Rate

Five schools returned a blank questionnaire, saying they were too busy to complete it. By 7 December 1993 we had received 547 replies. Reminder letters were then sent out, yielding a further seventy-three replies. So by the end of January 1994, the total number of replies was 620, a response rate of 60 per cent, (61 per cent from England, 52 per cent from Wales).

Responses were obtained from every LEA in England and Wales except nine. These were four inner London LEAs, three outer ones, and two county LEAs. The response rates vary from area to area. Fewer than a third of schools contacted in the inner London boroughs replied, but twice that proportion responded from the outer London boroughs. Fewer than 50 per cent of questionnaires were returned from six county LEAs, but in all other areas we received more than half of our questionnaires fully completed. Overall less than a 50 per cent response was received from 17 per cent of the LEAs. Between 50 per cent and 75 per cent responded from 49 per cent of the LEAs and over 75 per cent from 26 per cent. (For the full sampling details and regional breakdown see Bendelow, Lee, Mayall, Oakley and Storey, 1994, Appendix 2.)

Representativeness of the Respondent Schools

Since there was some variation in response rate according to area, with inner London somewhat underrepresented, we were anxious to see how far the sample was representative of the national picture. We set some of the background variables, the age-range of schools, the numbers of children on the school roll, and the denomination of the school against available national figures.

The proportions of different age-range schools in the national sample match almost exactly those in our study, with 25 per cent of schools in both our study and the national sample catering for infants, 14 per cent compared with 15 per cent for junior/middle, and 61 per cent compared with 60 per cent for 4/5–11/12s.

On numbers of children attending each school, our percentages broadly match those for England and Wales. Comparisons are derived from the most recent statistics available: Government Statistical Service (1993) *Statistics of Schools, January 1992*, England, Department for Education; Government Statistical Service (1993) *Statistics of Education and Training in Wales*, No. 1 (for 1991–2), Welsh Office. Eighteen per cent of schools in our study had less than 100 children compared with 20 per cent in the national sample, 31 per cent compared with 33 per cent had between 100 and 199 children and 51 per cent of our sample had two hundred or more compared with 47 per cent nationally.

On denominational status, two thirds (66 per cent) were non-denominational, just under a quarter (24 per cent) Church of England and 9 per cent Roman Catholic. These match almost exactly the national picture (67 per cent, 23 per cent, 9 per cent).

It is possible to make only a limited comparison between large-scale figures and ours, on the age of the school building. According to a DfE spokesperson (oral communication), there has been no large-scale investigation

Table A1.1 Age of primary school buildings in our survey compared with national studies (%)

	Age of buildings				N
	Pre-1903	1903–44	1945–64	1965+	
DES (1962)	60	24	16	—	21 055
DES/Welsh Off (1976)	35	20	46*	—	23 000
Our Study	30	13	15	42	590

* Includes all schools built since 1945.

Sources for Table A1: DES 1962 study, quoted in Central Advisory Council for Education (England) (1967) Vol. 1 (Report) (The Plowden Report) Table 29, Chapter 28; DES and Welsh Office (1977) A Study of School Building: Report by an Inter-Department Group, London: HMSO.

on this topic by the Department since 1976, and a library search has also revealed no later data. In any case, as we have noted, the age of the building is only a rough guide, since respondents may not have known it accurately, and many schools have newer buildings tacked on to older ones. As the years pass, more older buildings are abandoned in favour of new buildings. Comparative data on this topic is set out in Table A1.1. Our study shows quite high proportions of schools still in nineteenth-century buildings: 30 per cent compared to 35 per cent in the 1976 DES/Welsh Office study. It would be useful to compare our percentages with those of a more recent national study.

In summary, although the response rate to the questionnaire varied by LEA, the sample included schools from all parts of England and Wales and is broadly representative of all primary schools with regard to age-range, size of school, and denominational status.

This is the postal questionnaire, set out here with reduced spacing. As used, it was a 4-page, 8-sided document, with space for additional comments, and the last page reserved for comments (Section F). Ratings (for instance in questions C5 and E1) were set out so that respondents could circle the appropriate number on each topic.

HEALTH IN PRIMARY SCHOOLS

A **Characteristics of School**

A1 **How many pupils are there (excluding nursery class)?**
Is there a nursery class?
(N.B. All subsequent questions exclude the nursery class/school.)

A2 **Is your school denominational?**
Church of England; Roman Catholic; Other (*please specify*)

A3 **Is your school** Maintained; Opted out

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A4(a) **How would you describe the catchment area?**
Inner city; City; Large town; Small town; Rural
(b) **What is the approximate radius of your catchment area?**
Up to ½ mile; Up to 1 mile; Up to 2 miles; Over 2 miles

A5 **Is the school**: Mixed; Single sex _______

A6 **What is the age range within the school?**
5–11; 4/5–8; 8–12/13; Other (*please specify*)

A7 **How are the classes grouped?** (*Please list*)
Total number of classes _______

A8 **Please list all members of staff on pay roll**:
Head; Class teachers; Special Needs teachers; Other teachers; Admin/secretarial; NTAs(Non-teaching assistants)*; Caretaker; **Total paid adults** _______
(**Includes classroom helpers, playground and dinner supervisors, special needs support*.)

A9 **Do you have regular unpaid help with any of the following?**
Swimming/sports; School trips; In class; Other (*please specify*) . . .

A10 **Is there a PTA or other similar association?**

A11 **What is the age and style of the school building?**
Approximate age:
Pre-1875; 1875–1903; 1903–1944; 1944–1965; 1965–present
Style:
Old school house (with modern additions); Victorian purpose-built on 2+ floors;
Modern building; Prefabs; Other (*please specify*)

B **Health Education**

B1(a) **Does the school have an agreed policy on health education?**
(b) **Does this build on/use LEA policy?**

B2(a) **How is health education included in the curriculum?**
Through cross-curricular topics; Through science topics; Through HE topics; As the opportunity arises; Not at all; Other (*please specify*)
(b) **Does it run across school years (spiral curriculum)?**
(c) **Do you have block projects for specific age-groups?**
If yes, **please indicate which years/age-groups?**

B3 **Do you use guidelines from the Department for Education or NCC?**
Do you use specific packages? (e.g., HEA, commercial, etc.)
Which ones?

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B4 **Is there a designated member of staff/ group of staff/ health education coordinator responsible for the school health education curriculum?**

If yes, who? Headteacher; Deputy/ assistant headteacher;
Senior teacher; Class teacher; Group of teachers

B5 **Do you have a whole school health education policy apart from the formal curriculum?**

B6 **Do you aim to promote healthy behaviours in any of the following areas?**

No Yes, in general Yes, specific policy
Nutrition; Exercise; Safety; Personal relationships;
Risky activities; Personal health; Dental care; Other (*please specify*)

B7 **During the last school year (1992–93), did any person apart from school staff discuss health education issues with the children in school?**

School nurse; Health visitors; Nurse tutors; Police;
Other health professionals; Parents; Others (*please specify*)

C **Health Maintenance**

C1 **Does any member of staff have health-care training or qualifications in first-aid?**

Staff; Type of Training; Duration of Training (e.g., *half day, 1+week, 2 years, etc.*)
Total number of staff with training/ qualifications

C2 **Do you feel that the present arrangements for treating and caring for children when they become ill at school are satisfactory? Are there written school guidelines/ policies for the following:**

(a) A child becoming ill at school?
(b) A child having an accident at school?

C3 **Please list the most recent 3 accidents which have taken place this term where a child was out of class/work for ½ hour or more** (*please note body part, type of injury, place of accident and whether parent/guardian summoned*).

C4 **What accommodation is available to care for children?**

(a) **Is there a designated first-aid or 'casualty' room?**
Sole use Shared use No
(b) **If shared, with whom?**
School Health Service; Supervisors; Secretary; Head; Other (*please specify*)
(c) **Is the first-aid equipment adequate in**: quantity? quality?

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C5 **Thinking of the provision in this school, how would you rate the following in terms of promoting children's health?**
Curricular exercise/ PE; Opportunities for play;
The school buildings; Other (*please specify*)
(*Rating on a scale of Very good equals 1 and very poor equals 5*)

C6 **Snacks (e.g., milk, fruit, sweets, drinks)**
(a) **Are any foods/drinks prohibited?** (*If yes, please specify*)
(b) **Are any food/drinks provided or sold?** (*If yes, please specify*)

C7 **Packed Lunches**
Are packed lunches allowed?
Are any foods/drinks prohibited in packed lunches?
(*If yes, please specify*)

C8 **School Dinners**
Who provides school dinners?
None provided; LEA; Catering firm; School; Other (*please specify*)

C9 **What are the arrangements between the school and the providers to determine the character of the menus?**
Policy meetings/ discussions; Ad hoc liaison; None; Other (*please specify*)

C10 **Do the children play any part in determining menus?**

C11 **How would you rate the quantity and quality of school dinners?**
Quantity; Quality;
(*Rating on a scale of Very good equals 1 and very poor equals 5*)

C12 **Is provision made in school meals for the following dietary preferences/needs?**
Vegetarian/ vegan; Ethnic/ religious; Health conditions;
Other (*please specify*)

D **The School Health Service (SHS)**

D1 **Which health service staff visit the school and how often?**
Number of sessions per term or year
School Nurse; School Doctor; Dentist; Other health personnel (*please specify*)

D2 **What services are offered?**
Whole class surveillance; Consultation on request; Health interview; Hearing tests; Sight tests; Dental check, Other (*please specify*)

D3 **What accommodation is available specifically for the SHS?**
Sole use of room; Shared room; No room;
Other (*please specify*)

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D4 **Are there agreed procedures for liaison to take place between the SHS and the school?**
with Head; with Teachers; with Parents;

D5 **During the school year 1992–93, did the SHS have any input into health education at the school?**

D6 **How satisfactory is the input from the SHS to the health system of the school?**
Quantity; Quality

D7 **We are interested in the turnover of SHS staff. Over the last 3 years (90–91, 91–92, 92–93) how many of the following personnel have there been (including the present post-holder)?**
Doctors; Nurses; Dentists; Others (*please specify*)

D8 **Are you happy with the contribution of the SHS to the health of the children?**
And to the school more generally?

D9 **Do you have suggestions for improvement of the SHS contribution?** What?

E **The Physical Environment of the School**

E1 **How would you rate the school building, staffing and outside space as regards the maintenance and promotion of good child health?**
Playground 1; Playground 2; Playground Equipment; Standard of classrooms; Standard of toilets/ cloakrooms; Heating; Ventilation; Cleaning; Caretaking; Numbers of staff (all types); Types of staff

E2 **Are any plans in hand to modify the school environment, or to adapt it, in order to improve prospects for child health? Please list your priorities for effecting improvements.**

E3 **What input has the school received from the LEA to ensure the health and safety of the children since Sept 92 to date?**
Inspection/visit re health, safety, etc; Guidance, advice, modifications/ improvements/repairs; None; Other input (*please specify*)

E4 **In your opinion is the LEA input adequate, as regards the children's physical health and safety, in your school?**
Please add any further comments.

F **Taking Account of the Preceding Topic Areas, Please Add Any General Comments on the School as a Health-care Environment for the Children**

F1 **What do you think are the particular strengths of your school as regards the health care of the children?**

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F2 **Does your school have any particular weaknesses?**

F3 **Do you face any specific problems in maintaining and restoring children's health?**

F4 **Do you have any proposals/plans for improvements?**

F5 **Please add any further comments you feel are important and which may help the research.**

Appendix 2 Additional Tables

Table A2.1 Percentage of Survey schools by number of children and location

Number of children in school	*Schools by location*					*All schools*
	Inner city	City	Large town	Small town	Rural	
Under 100	8	3	3	7	52	18
100–149	6	7	9	17	20	14
150–199	16	20	21	19	10	17
200–249	24	26	28	30	8	22
250–299	19	13	20	12	6	13
300+	27	31	19	16	4	16
N	63	61	114	175	162	575

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Table A2.2: Children per teacher, per other staff and per all school staff, by location and by number of children in school (%)

Ratio	*Survey Schools by Location*				
	All schools	Inner-City	City Large town	Small town	Rural
Children per teacher					
1–15	13	13	7	4	31
16–19	27	35	24	27	27
20–24	50	49	53	56	38
25 or more	10	3	16	13	4
Children per other staff					
1–15	31	26	18	26	51
16–19	22	31	21	22	20
20–24	20	19	23	19	19
25–29	11	9	16	14	4
30–34	6	7	8	6	3
35 or more	10	9	14	14	3
Children per all staff					
1–7	19	13	9	13	40
8–9	24	36	17	23	27
10–11	26	24	32	27	21
12–13	18	11	27	22	6
14 or more	12	16	15	15	6
N	570	63	173	172	162

Ratio	*By number of children in school*		
	Under 100	100–199	200 or more
Children per all staff			
1–7	70	19	1
8–9	19	41	15
10–11	6	23	36
12–13	4	8	28
14 or more	1	8	20
N	107	177	297

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Table A2.3 Age of survey school buildings by location, denomination, age-range of school and number of children in school (%)

	Age of the school building				N
	Pre-1903	1903–1944	1944–1965	Post-1965	
By location					
Inner city	22	20	27	32	60
City	21	24	21	34	62
Large town	17	10	25	48	118
Small town	22	14	11	53	184
Rural	56	9	5	30	152
By denomination					
Non-denominational	24	18	19	40	387
Church of England	53	3	4	40	139
Roman Catholic	14	13	16	57	56
By age-range					
4/5–11	33	10	13	44	356
4/5–7/8	27	19	15	39	148
7/8–11/12	17	20	27	36	81
By number of children					
Under 100	70	7	5	18	103
100–199	31	12	17	40	171
200 or more	14	16	19	51	285

Tables Relating to Case-studies (but see p. 241)

Table A2.4 Nurse (SN) and doctor (Dr) visits to case-study schools per annum by number of children in school

School	*No. of children*		*Visits by*	
		SN+Dr	ch'n/SN	ch'n/SN+Dr
City	360	39	10.9	9.2
County	550	18	45.8	30.5
North	370	34	11.2	10.9
Infant	150	33*	4.5	4.5
Town	350	15	29	23.3
Village	107	12	11.8	8.9

* Infant had no doctor visits

Table A2.5 Changes in numbers of children and staff in case-study schools (1994–5 compared to 1995–6)

School	*Children*		*Staff*
	94–95	*95–96*	*95–96*
City	360	450	gained 1 teacher + 2 SN* assistants
County	550	600	gained 1 classroom assistant
North	371	364	lost 1 teacher
Infant	151	151	gained 1 SN assistant
Town	318	356	no change
Village	105	105	gained 1 classroom assistant

* SN — special need

Appendix 3 Survey Indexes

We constructed a series of indexes to combine data to provide overall measures of quality in specific areas of interest. These indexes comprise survey responses from a variety of questions and include ratings which are highly subjective. However, these indexes do enable certain areas of interest to be explored further; for instance, by putting the score for the physical environment against the age or location of schools.

Indexes were constructed on the physical environment of the school, health maintenance, health education, school health service, and liaison/input.

We did not rate the case-study schools on these indexes, since the data is more complex; and the comparison with survey data might be misleading.

Index of the Physical Environment

This index combines the following responses from the questionnaire. The maximum score is 8, minimum score –6. The index is computed for schools which gave valid answers for minimum of seven questions.

1 LEA has provided inspection, repairs or other input for health and safety, score 1
2 Playground rated very good, score 1; rated poor or very poor, score –1
3 Classrooms rated very good, score 1; rated poor or very poor, score –1
4 Toilets rated very good, score 1; rated poor or very poor, score –1
5 Heating rated very good, score 1; rated poor or very poor, score –1
6 Cleaning rated very good, score 1; rated poor or very poor, score –1
7 Playground equipment rated very good or good, score 1; rated poor or very poor, score –1
8 LEA input rated as good or very good, score 1

Distribution

Score	No. of schools	%
–6 to –2	106	17.1
–1 to 0	182	29.4

1 to 2	169	28.2
2 to 8	143	23.1
Missing	20	3.2

Among all schools, the age of the building was the only significant variable, with post-1966 buildings scoring the highest, the late Victorian (1875–1903) the lowest. However for schools describing their situation as rural or inner-city, the age of the building is not significant for the score on this index. City, large and small town schools all show significant differences by the age of the building in their scores. Schools reported as built before 1903 score lowest, those post-1966 the highest.

Table A3.1 Scores on Physical Environment Index by age of school building (%)

Index score		Age of building		
	All schools	Pre-1903	1903–1965	Post-1965
-6 to -2	18	24	22	10
-1 to 0	30	32	26	31
1 to 2	28	24	29	30
3 to 8	24	19	22	29
Total	571	168	163	240

Index for Health Maintenance

The index is computed for schools which provide valid responses to at least seven of the following questions, maximum score 8, minimum −2. No schools scored the maximum 8 points, mainly because most lacked a first-aid room and because school dinners were rated as average.

1. School prohibits sweets or fizzy drinks, score 1
2. Written guidelines for care of child taken ill and of child experiencing accident, score 1
3. Designated first-aid room sole use or shared with SHS, score 1
4. Staff trained in first-aid (at least one member of staff per 60 children), score 1
5. School dinner rated for quality, very good score 1; poor or very poor score −1
6. Policy meetings: discussions between school and providers of school meal, score 1
7. Curricular exercise PE rated for promoting health, very good, score 1; poor or very poor, score −1
8. Opportunities for play rated for promoting health, very good, score 1; poor or very poor, score −1

Distribution

Score	**Number of schools**	**%**
−2 to 1	196	31.6
2	141	22.7
3	118	19.0
4 to 6	63	11.1
Missing	50	8.1

Good scores on this index are significantly related to good scores on the Index of the Physical Environment. Those scoring badly on health maintenance scored badly on the building and those scoring well on health maintenance are those reporting favourably on the school building. Age of building is significant with those built post-1965 scoring well, pre-1903 the lowest with 1875–1903 rather worse than pre-1875.

A possible explanation is that only 4 per cent of pre-1875 and 14 per cent of 1875–1903 schools have a separate first-aid room or one shared with SHS compared with 23 per cent of those built after 1944. The rating of PE and opportunities for play is less good for the older schools. More difficult to explain is why quality of dinners is rated lower in the older schools, 22 per cent poor compared with 12 per cent in the post-1965 schools. Possibly this is because older schools are disproportionately rural and dinners are 'bused' in.

Table A3.2: Scores on the Health Maintenance Index by the age of school building (%)

Index score		*Age of school building*		
	All schools	Pre-1903	1903–1965	Post-1965
−2 to 1	34	43	35	27
2	25	26	24	24
3	21	15	23	23
4 to 6	20	16	18	25
N	543	159	161	223

Table A3.3: Scores on the Health Maintenance Index by scores on Physical Environment Index

Score on Health Maintenance Index	*Physical Environment Index*	
	Lowest score	Highest score
	−6 to −2	3–8
−2 to 1	48	16
2	31	19
3	18	20
4 to 6	3	45
N	98	132

Index for Health Education

The index is computed for schools which gave valid answers for a minimum of three questions. The maximum score is 5, minimum 0.

1. School has health education policy, score 1
2. School has a whole school health education policy apart from formal curriculum, score 1
3. School has designated member of staff responsible for health education, score 1
4. School aims to promote healthy behaviours by specific policies: in three or more areas, score 2; one or two areas, score 1

Distribution

Score	**Number of schools**	%
0 to 1	213	34.4
2	117	18.9
3	163	26.4
4 to 5	125	20.2
Missing	2	0.3

On this index, 14 per cent of schools score 0 and 20 per cent score 5 (the maximum) or 4. There are significant differences by the age-range of schools, so that infant schools score lower than primary schools and primary schools score lower than junior schools. There are no differences by location or size of school. Schools teaching health education through health education topics score significantly higher than those who do not. Teaching health education through science topics is also significant, but cross-curricular and opportunistic teaching do not signify.

Schools scoring well on the Health Education Index have higher ratings on the Health Maintenance Index. Similarly those schools scoring low on this index have significantly lower scores on the Maintenance Index. Whilst this continues to be true for all infant and for all primary schools, when junior

Table A3.4 Scores on the Health Education Index by the age-range of the school (%)

Index score		*Age-range*		
	All schools	Infant	All-age Primary	Junior
0 to 1	34	42	35	19
2	19	15	19	25
3	27	23	26	36
4 to 5	20	20	21	19
N	612	154	375	83

schools only are considered, this association is no longer significant. (Does this suggest that some are putting out the messages but not backing it up with the action?) Similarly, the two are significantly linked for the town and large town schools, but not in the inner-city, city or rural schools.

School Health Service (SHS) Index

This index aims to construct an overall picture of the service a school is getting from the school health service. The maximum score is 6, minimum –3, and is computed for schools which provide valid responses to a minimum of 6 questions.

1. Nurse visits per pupil (at least one visit per year for each ten pupils), score 1
2. Nurse turnover (more than two school nurses in past three years), score –1
3. Satisfaction with quantity of SHS to health system of school, very good, score 1; poor or very poor, score –1
4. Satisfaction with quality of SHS to health system of school, very good, score 1; poor or very poor, score –1
5. Agreed procedures for liaison with school head or teachers, score 1
6. SHS has own room or shared with first aid, score 1
7. Agreed procedures for liaison wih parents, score 1

Distribution

Score	**Number of schools**	**%**
–3 to 0	146	23.5
1	119	19.2
2	136	21.9
3 to 6	175	28.2
Missing	44	7.1

There are no significant differences by age-range of school, location, or number of pupils. Perhaps this indicates that local health service policies and traditions determine the character of the SHS rather than school characteristics.

Index of Liaison/Input

This index brings together a range of responses which give an indication of the degree to which the school interacts with outside agencies. The maximum score is 7, minimum score 0, and the index is computed for schools giving valid responses to a minimum of six questions.

1. Regular unpaid help in school (assistance in three of four areas), score 1
2. PTA or similar association, score 1
3. Outside speakers involved in health education, two or more, score 1.
4. SHS liaison with head teacher, score 1
5. SHS liaison with parents, score 1
6. Policy discussions on dinner menu, score 1
7. LEA input rated as very good or good, score 1

Distribution

Score	**Number of schools**	**%**
0 to 2	119	19.2
3	173	27.9
4	128	20.6
5	183	29.5
Missing	17	2.7

There are some differences by location with schools in rural areas scoring significantly higher than schools in city and town areas. Schools scoring well on health maintenance and on health education indexes score significantly higher on this, even when the liaison/input index is constructed without the health education (3) or health maintenance (6) factors.

Table A3.5 Scores on Input and Liaison Index by age-range of school and by location (%)

Index score	*Age-range*			
	All schools	Infant	All-age Primary	Junior
0–2	20	26	17	21
3	29	28	30	26
4	21	24	20	22
5 or more	30	23	33	31
N	597	152	368	177

Index score	*Location*		
	Inner-city and City	Town	Rural
0–2	26	20	13
3	28	30	27
4	25	20	22
5 or more	21	30	38
N	125	305	159

Appendix 4 Case-study Interviewees and Schedules

In the six case-study schools data were collected from adults and children. (For children see p. 257.)

Adults

City

Staff interviews

headteacher
deputy head who was also class teacher of a Year 6 class
class teacher of Year 1 class
class teacher of a middle junior class, with responsibility for health education and PSHE
secretary
playtime supervisor/welfare helper
school nurse

Parents

6 mothers interviewed, four singly and two together
19 parent questionnaires

County

Staff interviews

acting headteacher
class teacher of Year 3 class
class teacher of Year 6 class
special needs assistant
welfare assistant
administrator
secretary
school nurse

Parents

4 mothers — group interview
12 parent questionnaires

North

Staff interviews

headteacher
class teacher of Year 6 class
health education coordinator
PSE coordinator
secretary
cook
group of four supervisors (one interview)
educational welfare officer, based in the school but working in several schools
school nurse

Parents

4 mothers and 1 father (a classroom helper) interviewed
4 parent questionnaires

Infant

Staff interviews

headteacher
class teacher of Year 1 class
non-teaching assistant
secretary
supervisor
school nurse
school meals officer for the LEA

Parents

5 mothers — group interview
15 questionnaires

Town

Staff interviews

headteacher
class teacher of Year 1 class
class teacher of Year 6 class

teacher responsible for PE
teacher responsible for health education
bursar
cook
school nurse

Parents

1 mother — interview
33 questionnaires

Village

Staff interviews

headteacher
class teacher of Class 2 (6–7-year-olds)
class teacher of Class 4 (9–11-year-olds)
secretary
school nurse

Parents

3 mothers — interviews
6 parent questionnaires

Table A4.1: Interviewees at case-study schools

Interview with	*Case-study School*						
	City	County	North	Infant	Town	Village	All
Headteacher	1	1	1	1	1	1	6
Teachers — older class	1	1	1	—	1	1	5
Teachers — younger class	1	1	—	1	1	1	5
Other teachers	1	—	2	—	2	—	5
Lunchtime supervisors	1	—	1	1	—	1	4
Cook	—	—	1	—	1	—	2
Administrator	—	1	—	—	1	—	2
Secretary	1	1	1	1	—	1	5
Classroom helpers	—	1	—	1	—	—	2
School nurse	1	1	1	1	1	—	5
EWO	—	—	1	—	—	—	1
Welfare assistant	—	1	—	—	—	—	1
School meals coord	—	—	—	1	—	—	1
Total staff interviews	7	8	9	7	8	5	44
Parent governor	—	—	—	—	—	1	1
Parent interviews	6	3	5	5	1	2	22
Parent questionnaire	19	12	4	15	33	6	89
Total parent response	25	15	9	20	34	9	112
Younger children class nos	28	28	—	30	27	19	132
Older children class nos	19	25	22	—	33	33	132
Total children class nos	47	53	22	30	60	52	264

Table A4.2 Case-study schools: parent questionnaires — numbers sent and returned

School	*Questionnaires*			Number received			
				Younger class		Older class	
	Sent N	Returned n	%	Girls	Boys	Girls	Boys
City	47	19	40	8	4	6	1
County	53	12	23	4	5	2	1
North	22	4	18	—	—	2	2
Infant	30	15	50	10	5	—	—
Town	61	33	54	11	6	7	9
Village	54	6	11	2	2	—	2
Total	267	89	33	35	22	17	15

Interviews with Staff

1 *Non-teachers* Can you tell me about your role, the sort of things you do here at the school.
And what sort of contacts do you have with the children?

Teachers Apart from your responsibility for your class, do you have other responsibilities in the school?

2 What part do you play as to the children's exercise (i.e., in the curriculum and in playground/playtime)?
How do you feel about that?

3 How far do you think the children you work with look after themselves during their school day?

Dealing with Illness and Accident

4a Can you tell me about the most recent case where a child came for help — because s/he was *ill or in distress*.

Prompt: What happened?
What did you do?
Did it turn out alright for the child?

4b Can you tell me the most recent *accident*, where you played a part?

Prompt: What happened?
What did you do?
Did it turn out alright for the child?

Children Who Need Special Care

5 *For class teachers/special needs helpers*
Are there some children in the class who need special care?

For each such child:

5a What sort of special care do you give?

5b What are the main issues that arise in caring for this child?
(e.g., building, class size, curriculum)

5c Do you get any extra support (e.g., visiting health staff), information, guidance (written information, guidelines)?
Do you need more help?

5d What part does the child's parent play in discussing care of the child with you or with the school?

5e What part does the child her/him self play in managing her/his problem?

Health Education

6a How do you see the role of health education (formal or informal) in the school?

Prompt: How well is it working at present?

6b Do you yourself take part in health education (either formally or informally)?

6c Do you have any suggestions for changing health education in this school?

6d Do you have any views on children's food at school (inc. school dinners/packed lunches/snacks)?

School Health Service

7a What do you think about the contribution of the school health service to the care of the children?

7b Is it satisfactory in terms of quantity, quality, liaison?

7c Do you play any part in liaison with the SHS?

School Building and Environment

8a The school buildings and outside spaces — are they good/adequate from the point of view of maintaining the children's health?

Prompt: What about air quality?
What about the toilets and washing facilities for children?

8b Are there any changes you would like to see?

General

9 Do you think being at school is good for the children's health?

10a What do you see as the principal strengths of this school, as regards caring for the children?

10b Does the school have any weaknesses in this respect?

11 Are there any changes in the school you would like to see?

12 Is it easy for the school to look after the children?
What are the issues, problems?

Parent Group Discussions — Topics

1 *Caring for the Children at School*
- What are the strengths of the school as regards caring for the children.
- Are there any problems?
- What about care given if children are ill — and liaison with parents
- What happens if children have an accident — and liaison with parents
- Do you have any suggestions for change?

2 *Parent–Teacher Discussion about Child Care at School*
- Do you talk with your child's class teacher about the care of the child?
- And with the head — or anyone else?
- Does that sort of contact go well?
- Some parents find it easier than others to talk with teachers; why do you think that is?
- Do you have any suggestions to make contact better or easier?

3 *The School Environment*
Thinking about the well-being of the children, are you happy with:
- the physical environment of the school
- school food (school dinners, packed lunches, snacks)
- opportunities for exercise
- the school health service

4 *Health Education*
- What do you see as the role of the school in helping children stay healthy? And keeping safe?
- Do you have suggestions for developing this aspect of the school?

5 *Child Health*

- Do you think the children flourish at school?
- To what extent do they look after themselves?

Parent Questionnaire

Please ring number: 1 — good; 2 — some problems; 3 — poor

School Environment

Do you think the school building is adequate
as a place for the children to spend their days? 1 2 3

And the outside space? 1 2 3

Any suggestions for improvements?

Health Maintenance

Does the school look after the children's health well? 1 2 3

Have you been happy with the care they offered
    when your child was last ill 1 2 3
    and when s/he had an accident 1 2 3

Does the school liaise well with you on health matters? 1 2 3

Are you happy with:
    opportunities for exercise 1 2 3
    school dinners 1 2 3
    packed lunches 1 2 3
    safety aspects of school 1 2 3
    hygiene aspects of school 1 2 3

Does your child have any on-going health problem/condition? YES/NO

Please say what it is
    Are you happy with your contact with the school on this? 1 2 3
    Does the school look after your child well? 1 2 3

School Health Service (SHS)

Do you think the SHS offers your child a good service? 1 2 3

To your knowledge, has she or he ever asked the nurse or
doctor for advice or help? YES/NO

Have you ever asked the nurse or doctor for advice or help regarding your child? YES/NO

Are there any changes/improvements to the SHS you would suggest?

Data Collection with Children

Table A4.3 Case-study schools: number of children in each class studied

Class	Case-study Schools						
	City	County	North	Infant	Town	Village	Total Children
Younger	28	28	—	30	27	19	132
Older	19	25	22	—	33	33	132

During the fieldwork period in each school — about four weeks — data were collected with children in two main ways, through interviews and through topic work. Other data collection methods were used as time permitted, and in accordance with the children's inclination.

Interviews were carried out with 256 children (i.e., 8 absences/not available). There were 124 interviews, mostly in pairs: 117 pairs, 6 with 3 children, and 1 with 4 children — i.e., 124 interviews and 256 children. There were 61 younger children interviews and 63 older children interviews.

The choice of pairings and groupings varied; children chose their companion/s; in some cases teachers organized a list of pairs; in others, availability and convenience were factors. Most interviews were carried out in single sex pairings or groupings: there were 49 with girls, 53 with boys, and 22 with mixed pairs or groups (39.5 per cent, 42.7 per cent and 17.7 per cent respectively). Where the analysis is by interview and by sex, the mixed interviews have been omitted.

Interview Questions

1a What are the best things about school?
b And the worst?
c What places in school are you happiest in?
d Are there any bad places?

If not mentioned: what about the classroom, the playground, the toilets, the dinner-room?

1e Which times of the school day do you like best, and is there any time you especially dislike?

2 Can you tell me about a time when you felt ill — what happened, who helped you? Was that OK for you?

3 And can you tell me about a time when you had an accident — what happened, who helped you? Was that OK?

4 What is school like now, compared to when you were smaller/in reception class?

5 If you didn't have to come to school, would you?

Topic Work

In addition, data were collected from the children through topic work. The main topics addressed were:

What keeps you healthy?
Where does health care take place?
Whose job is it to keep you healthy?
Do you do healthy things at school? and unhealthy things?

Children were asked to write brief answers on these topics. This written work was carried out with younger children at County, Infant, Town and Village schools; and with older children at County, North, Town and Village schools. At City, the first case-study school, the topics were covered more informally during interviews.

Other topics addressed with some children

If there was something you could change about school what would it be?

Have you done any topics/work on things like: my body, dental care, diet, relationships, safety? Did you enjoy that?

Have you seen a doctor, nurse, dentist at school? Do you think it's a good idea to have these people come — In general? For you?

Some children did drawings

Topics included: me at school; in the playground; school dinner; an accident; a healthy and unhealthy person

Some older children wrote

Topics included: playtime; the end of the day; what I like and dislike about school.

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Children's Health in Primary Schools

[illegible]

Berry Mayall, Gillian Bendelow, Sandy Barker, Pamela Storey and Marijcke Veltman [illegible]

Falmer Press

ISBN 0-7507-0545-0

9 780750 705455

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U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement (OERI)
Educational Resources Information Center (ERIC)

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PS024837